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Quality of Life in Europe: Social Inequalities

Abstract

[Excerpt] This report uses data from the European Quality of Life Survey (EQLS) to examine social inequalities in quality of life in the European Union. Four critical domains of life are examined: health, standard of living, productive and valued activities, and individual, family and social life. Variation in these four domains is measured by gender, age, disability status, employment status and citizenship status. The role of other important drivers of social inequalities such as educational status, occupational group, urbanisation, gross domestic product (GDP) per capita, income, welfare regime and healthcare system is also discussed. The results of the third EQLS (2011) are compared with those of the second EQLS (2007) to assess the impact of the economic crisis on social inequalities and on the disadvantages experienced by population subgroups in Europe.

Keywords

European Union, quality of life, policy, social inequality

Comments

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Quality of life
in Europe:
**Social
inequalities**



3rd

European
Quality
of Life
Survey



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Authors: Ellie Suh, Tiffany Tsang, Polly Vizard and Asghar Zaidi with Tania Burchardt

Research managers: Hans Dubois and Tadas Leončikas

Project team for the third EQLS: Rob Anderson, Hans Dubois, Klára Fóti, Tadas Leončikas, Branislav Mikulić, Daniel Molinuevo and Eszter Sándor

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Abbreviations used in this report

AROPE	at risk of poverty or social exclusion
EMF	Equality Management Framework
EQLS	European Quality of Life Survey
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	gross domestic product
ILO	International Labour Organization
NGO	non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
WHO	World Health Organization
WHO-5	World Health Organization's Mental Well-being Index

Country groups

EU15	15 EU Member States prior to enlargement in 2004
EU12	12 EU Member States that joined in 2004 and 2007
EU27	27 EU Member States (as at the time of the survey)*

Country codes for EU27

AT	Austria	ES	Spain	MT	Malta
BE	Belgium	FI	Finland	NL	Netherlands
BG	Bulgaria	FR	France	PL	Poland
CY	Cyprus	HU	Hungary	PT	Portugal
CZ	Czech Republic	IE	Ireland	RO	Romania
DE	Germany	IT	Italy	SE	Sweden
DK	Denmark	LT	Lithuania	SI	Slovenia
EE	Estonia	LU	Luxembourg	SK	Slovakia
EL	Greece	LV	Latvia	UK	United Kingdom

* At the time of carrying out the third EQLS and of writing this report, Croatia's status was that of a candidate country for membership to the European Union. It became the 28th EU Member State on 1 July 2013.

Executive summary

Introduction

This report uses data from the European Quality of Life Survey (EQLS) to examine social inequalities in quality of life in the European Union. Four critical domains of life are examined: health, standard of living, productive and valued activities, and individual, family and social life. Variation in these four domains is measured by gender, age, disability status, employment status and citizenship status. The role of other important drivers of social inequalities such as educational status, occupational group, urbanisation, gross domestic product (GDP) per capita, income, welfare regime and healthcare system is also discussed. The results of the third EQLS (2011) are compared with those of the second EQLS (2007) to assess the impact of the economic crisis on social inequalities and on the disadvantages experienced by population subgroups in Europe.

Policy context

The objectives of social cohesion and inclusive growth are central to the Europe 2020 agenda. The European Commission in its Beyond GDP initiative has called for the development of new indicators that reflect the multidimensional aspects of well-being and for more accurate reporting on inequalities. Concern with social inequalities is reflected in a range of European policies such as the Strategy for Equality between Men and Women 2010–2015, the European Disability Strategy 2010–2020 and the European Parliament's 2011 resolution on health inequalities.

Key findings

Health

- Women, older people and unemployed people were found to be disadvantaged across a range of health indicators. People who report a limiting long-standing physical or mental health problem, illness or disability (referred to henceforth as a 'limiting disability or health condition') were more likely to experience difficulties accessing healthcare.

- Having a limiting disability or health condition, being older and being unemployed had a negative impact on self-reported general health. Material deprivation, low income, low educational attainment, poor-quality housing and difficulties accessing healthcare were other important factors.
- The proportion of the EU27 population reporting bad self-rated general health increased between 2007 and 2011. The increase in the proportion of young people whose mental health is at risk suggests the scarring effects of the crisis may be affecting their health and well-being.

Standard of living

- People with a limiting disability or health condition, older people, unemployed people and non-EU citizens were more likely to report material deprivation.
- Low income, being in a non-professional or non-managerial occupational group, and low educational attainment were associated with increased material deprivation, as were widowhood and lack of social support. National GDP and type of welfare regime were also important.
- The proportion of the EU population who experienced material deprivation increased between 2007 and 2011, with above-average increases among people with a limiting disability or health condition, the long-term unemployed and people aged 50–64.
- High proportions of users of long-term care experienced difficulties with the services they received.
- Difficulties with childcare cost and quality were pronounced among the unemployed.

Productive and valued activities

- Informal care activities were still mainly undertaken by women.
- Older people and people with a limiting disability or health condition made a major social contribution as providers of informal care in Europe.

- Informal carers of older people who were aged 65 or over or who had a limiting disability or health condition were often engaged in informal care activities for 20 or more hours a week.

Individual, family and social life

- Having a limiting disability or health condition and being unemployed were associated with disadvantage in relation to autonomy, treatment with dignity and respect, social support and social inclusion. Older age was a risk factor for lack of social support, with the disparities most pronounced for those aged 81 or over. Older age was found to be a risk factor for social exclusion in EU12 countries. Non-EU citizens were more likely to report feeling treated with a lack of dignity and respect, and to perceive themselves as being socially excluded.
- Poverty, low educational attainment and having a non-professional or non-managerial occupation were associated with increased social exclusion, as were bad self-reported health, widowhood and lack of social support.

Policy pointers

Concern over the multidimensional aspects of well-being needs to be coupled with effective public action to address social inequalities. Public action should not be restricted to specific measures at the margins, but rather integrated into general policies at the European and Member State levels. With budgets under pressure in many Member States, equality impact assessments can help to ensure that the burden of adjustment does not fall disproportionately on those already most disadvantaged.

Health

Multidimensional strategies that address the social determinants of poor health, including poor-quality housing, poverty and low educational attainment, should be adopted. With

unemployment high in some Member States, policies focusing on the poor mental health of unemployed people are needed. Specific action is required to address the gaps in the health status of people with a limiting disability or health condition, older people and unemployed people, and to tackle difficulties with health costs among those with a limiting disability or health condition.

Standard of living

Efforts to mainstream equality concerns into policy frameworks for reducing poverty by 2020 should be intensified. In addition to gender and disability mainstreaming, there is a need to address the needs of the long-term unemployed. Policies should recognise that the duration of unemployment is itself a key barrier to work. Availability of high-quality, accessible childcare to disadvantaged groups would help to remove impediments to labour market participation. Low-quality ratings for long-term care point towards policy failure; social insurance provides one possible model for the fair provision of care.

Productive and valued activities

Public policy frameworks that value, recognise and support the contribution of unpaid carers, including women, those with a limiting disability or health condition, and older people, are required. The unmet needs of informal carers should be formally evaluated, while the substantive options available to women in reconciling care and employment should be expanded.

Individual, family and social life

Public policy frameworks that address social inequalities in relation to lack of social support in times of personal crisis are required. These must encompass the needs and situations of older people, especially those aged 81 or over; informal carers of the elderly; widows and widowers; the unemployed; and non-EU citizens.

Introduction

This report uses data from the European Quality of Life Survey (EQLS) to examine social inequalities in the distribution of freedoms and opportunities among individuals and population subgroups in Europe. The EQLS provides a rich source of evidence on quality of life and collects information on a wide range of individual and subgroup characteristics. The first EQLS was conducted in 2003 and the second in 2007; the third and most recent round was conducted for the most part in 2011, with additional fieldwork in early 2012. The third EQLS covers the 27 European Union Member States as at the time of the survey, as well as seven other European candidate or pre-accession countries (including Croatia).

The report uses the third EQLS data from the EU27 Member States to build up an evidence base on social inequalities in four critical areas of life:

- health;
- standard of living;
- productive and valued activities;
- individual, family and social life.

Ten indicators were selected to evaluate these four domains, and findings have been systematically disaggregated by:

- gender;
- age;
- disability status;
- employment status;
- citizenship status.

The role of other important potential drivers of social inequalities such as educational attainment, occupational group, urban or rural location, gross domestic product (GDP) per capita, income, income inequality and social arrangements (such as different welfare and healthcare systems) is also discussed.

The report also examines the impact on social inequalities in Europe of the financial crisis that began in late 2007 and erupted into a full-blown economic crisis in 2008. Trends in quality of life outcomes over the period 2007–2011 are discussed, and the report identifies a number of instances where the relative position of disadvantaged population subgroups has further deteriorated.

Quality of life and the European policy agenda

There is growing recognition, both internationally and within the European Union, of the need for a much broader concept of economic and societal progress rooted in the notion of quality of life. The international Commission on the Measurement of Economic Performance and Social Progress (generally known as the Stiglitz–Sen–Fitoussi Commission) highlighted the limitations of GDP as a sole measure of economic performance and social progress (Stiglitz et al, 2009). The commission set out a series of recommendations on how to:

- shift the focus of measurement from production to well-being, including putting greater emphasis on income and consumption as well as economic production, for example, by measuring household disposable income, income distribution and poverty;
- recognise the multidimensional nature of well-being by developing broad statistical systems that capture the various multiple dimensions of well-being or quality of life.

The commission made specific recommendations on measuring the quality of life.

- Well-being must be recognised as multidimensional, with simultaneous consideration of material living standards, health, education, personal activities (for example, work and care), and political voice and governance.
- Assessing quality of life requires a plurality of indicators (although strong demands to develop a single index should also be facilitated).
- Both objective and subjective measures of well-being are important, and there is a need to go beyond self-reports and perceptions and to include ‘measures of ... “functionings” and freedoms ... the capabilities of people ... the extent of their opportunity set and their freedom to choose among this set, the life they value’ (Stiglitz et al, 2009, p. 15).
- Inequalities should be evaluated between socioeconomic groups, for example, by gender and with attention to new inequalities such as those associated with immigration.

Within the European Union, the Beyond GDP agenda is having a growing impact both within individual countries and at the EU level. In 2009, the European Commission challenged the use of GDP as a measure of overall societal development and progress in general, and called for additional indicators that capture and reflect the multidimensional aspects of well-being, as well as for more accurate reporting on distribution and inequalities along the various dimensions (European Commission, 2009a). The Commission's proposal for a new general EU Environment Action Programme to 2020 highlights the need for continued work on indicators to monitor social progress (European Commission, 2012a). In the recent communication 'A decent life for all', the Commission again pointed to the role of indicators beyond GDP and confirmed the need to continue developing such indicators (European Commission, 2013a). The 18-month programme of the European Council from 1 January 2013 to 30 June 2014 drawn up by the future Irish, Lithuanian and Greek Presidencies included an explicit commitment to advance 'work on developing indicators to complement GDP' (Council of the European Union, 2012a). The Beyond GDP agenda is also reflected in proposals to link the allocation of EU structural funds to quality of life rather than to GDP per capita (Vandermotten et al, 2011) and in numerous national initiatives in countries such as Austria, Belgium, Finland, France, Germany and the UK.

Social inequalities in quality of life

This emerging focus on the central and valuable domains of life and multiple dimensions of quality of life is coupled with increasing public policy concern with social inequalities. Social cohesion and inclusion are at the centre of the EU's growth strategy for 2020 (European Commission, 2010a), while the Commission's Beyond GDP proposals highlight the importance of distributional concerns, social and economic cohesion, and reducing disparities. Far-reaching reforms, it suggests, 'can only be achieved if efforts and benefits are felt to be equitably shared among countries, regions, and economic and social groups' (European Commission, 2009a). The objective of social cohesion is also emphasised in the recent Social Investment Package (European Commission, 2013b).

Concern with social inequalities in quality of life is reflected in numerous other strategies, policies and initiatives. One of the five headline targets of the Europe 2020 strategy is to lift at least 20 million people out of poverty and social exclusion by 2020. This has proved challenging in the economic climate of the past few years. The European Parliament's resolution on health inequalities highlights the need for policy frameworks to improve the health status of population subgroups including women, older people, people with disabilities and

disadvantaged migrant groups (European Parliament, 2011). This resolution recognises the link between health inequalities and socioeconomic inequalities. It also highlights a social gradient in the health outcomes experienced by people in lower-skilled occupations, those with a lower level of educational attainment and those with a low income.

The European social inequalities agenda is underpinned by an expanding body of standards on equality. Historically, concern with gender equality has been reflected in EU standards covering non-discrimination and equal pay for equal work. These have expanded over time to cover additional areas such as protection in pregnancy, equal treatment in social security and the prohibition of gender discrimination in relation to access to and the supply of goods and services. New EU equality standards cover non-discrimination in other areas such as:

- the ban on discrimination on racial grounds in the workplace and in relation to social protection and goods and services;
- the ban on discrimination on the grounds of age, disability, religion or belief and sexual orientation in relation to employment and vocational training.

EU equality strategies also increasingly adopt a human rights approach. For example, the European Disability Strategy 2010–2020 builds on the Charter of Fundamental Rights of the EU (which recognises the rights to non-discrimination, dignity and equality) and on the UN Convention on the Rights of People with Disabilities (European Commission, 2010c).

Equality mainstreaming is defined for the purposes of this report as 'the integration of the equalities perspective into general policies – including into policy design, implementation, monitoring and evaluation – with a view to achieving equality' (adapted from European Commission, 2010a, b).

The critical role that equality mainstreaming can play in the delivery of 2020 targets to reduce poverty and social exclusion is emphasised in the European Commission's evaluation of the European Year for Combating Poverty and Social Exclusion 2010 (Cancedda and McDonald, 2011). The Strategy for Equality between Women and Men 2010–2015 (European Commission, 2010b) and the European Disability Strategy 2010–2020 (European Commission, 2010c) also highlight the importance of greater equality for the delivery of the EU's 2020 growth agenda.

Impact of the economic crisis

There is growing concern across Europe about the impact of the economic crisis on social inequalities and income distribution. The events of recent years raise the possibility of overall declines in quality of life in Europe, coupled with a

deepening of the disadvantages experienced by some population subgroups and a widening of social inequalities. Indeed, this report is written against a background of growing evidence of the severe adverse consequences of the crisis for progress towards equality.

- In 2010 and 2011, the average unemployment rate in the EU27 was 9.7%. By January 2013 the figure had further increased to 10.8%, with the highest rates in Greece (27.0% in November 2012), Spain (26.2%) and Portugal (17.6%) (Eurostat, 2013a).
- The scarring effects of high youth unemployment in some Member States are likely to last for many years to come. In January 2013 the youth unemployment rate had reached 23.6% in the EU27, with rates of 59.4% in Greece (November 2012), 55.5% in Spain and 38.7% in Italy (Eurostat, 2013a).
- In 2011, 119.6 million people, or 24.2% of the population, in the EU27 were at risk of poverty or social exclusion compared with 23.6% in 2010 (Eurostat, 2013b).

The severe adverse impact of the crisis on employment conditions is established in a report commissioned by the International Labour Organization (ILO) (Vaughan-Whitehead, 2012). Income and living standards have suffered (Jenkins et al, 2011; Avram et al, 2013) and the proportion of European households struggling with debt problems has increased (Eurofound, 2012a). Analysis by the Organisation for Economic Co-operation and Development (OECD) suggests that the crisis put more pressure on market incomes (income from work and capital) in the 3 years to the end of 2010 than in the previous 12 years. While tax-benefit systems, reinforced by fiscal stimulus policies, have cushioned the effects on post-transfer incomes

to date, there is a growing risk that the most vulnerable will be hit harder in the period to come (OECD, 2013). Health has worsened especially among low-income groups (Eurofound, 2012b; European Parliament, 2012a, b) and suicides have increased (Stuckler et al, 2011). The EU's equality and disability strategies express concerns that one of the impacts of the economic downturn will be to widen social inequalities based on characteristics such as gender and disability (European Commission 2010a, b).

Content of the report

The report has six chapters. Chapter 1 explains how the social inequalities in quality of life in Europe have been evaluated for this report, including the conceptual framework and the selection of domains, indicators and disaggregation characteristics. Chapters 2 to 5 set out the findings on social inequalities in four critical areas – health (Chapter 2), standard of living (Chapter 3), productive and valued activities (Chapter 4) and individual, family and social life (Chapter 5). Chapter 6 concludes with a summary of key findings and policy pointers.

This report is one of a series of reports by Eurofound to examine the results from the third EQLS. These include the overview report *Quality of life in Europe: Impacts of the crisis* (Eurofound, 2012b) and reports on:

- subjective well-being;
- social inequalities;
- quality of society and public services;
- trends in quality of life in Europe (2003–2012).

CHAPTER 1

Conceptual framework for evaluating quality of life

Conceptual framework for evaluating quality of life

Equality Measurement Framework

To build up an evidence base on social inequalities in quality of life, this report makes use of the Equality Measurement Framework (EMF), developed specifically for the purposes of evaluating inequalities in the distribution of capabilities between individuals and population subgroups (Alkire et al, 2009; Burchardt and Vizard, 2011).¹ Figure 1 provides an overview of the EMF.

Capabilities

Conceptually, the EMF focuses on the idea of *capabilities* devised by the Nobel Prize-winning economist, Amartya Sen. A person's capability is the freedom and opportunity they have to live a life that they value and would choose.

The framework makes use of a capability list covering 10 central and critical areas of life (or 'domains') (Figure 1). This list was derived from the international human rights framework and through consultation with the public and at-risk groups. It includes, for example, the freedom and opportunity a person has:

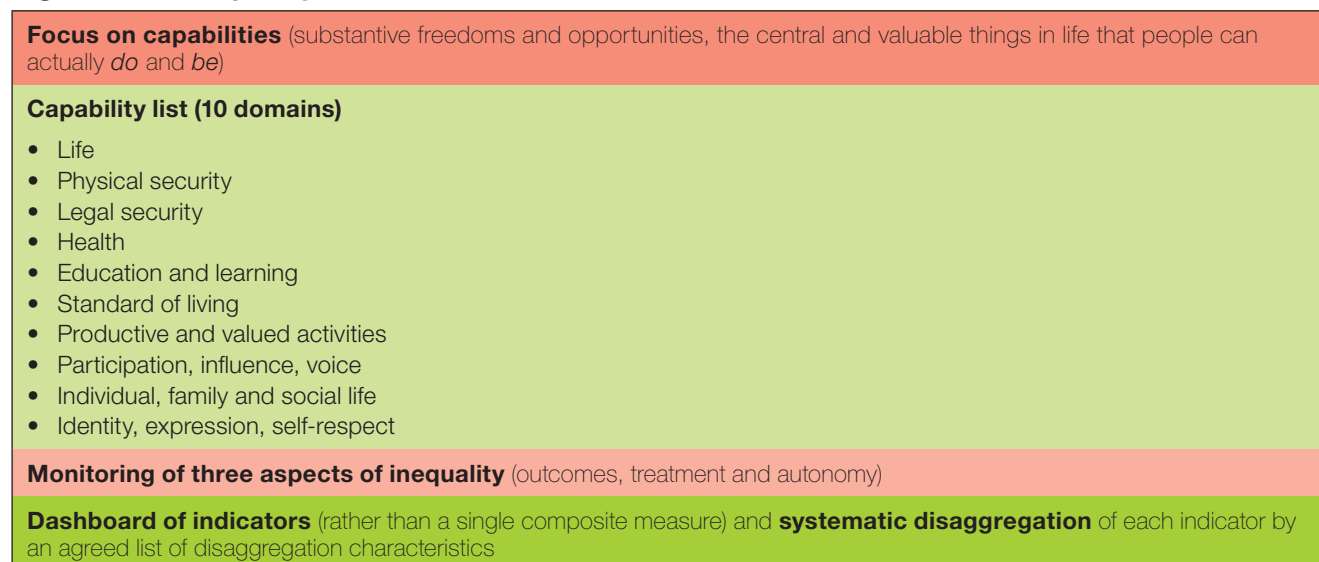
- to live a full life, avoiding homicide and premature mortality;
- to enjoy a good state of physical and mental health, avoiding illness, disease, injury, mental and emotional ill-health and so on;
- to live in physical security, avoiding interpersonal violence including domestic violence and sexual violence;
- to enjoy an adequate standard of living, with adequate income, housing and care;
- to participate in political decisions and public and community affairs.

Three aspects of inequality

In operationalising Sen's concept of capabilities, the EMF distinguishes between three critical aspects of inequality. These are:

- inequalities in outcomes (or 'achieved functionings' – what people are actually doing and being, such as their health status, or whether they are employed or not, or whether they are experiencing physical abuse);
- inequalities in autonomy (or empowerment, choice and control);
- inequalities in treatment (for example, whether a person is experiencing discrimination, whether they experience inhumane or degrading treatment, and whether they are treated with dignity and respect).

¹ The EMF was developed in partnership with the British Equality and Human Rights Commission (EHRC).

Figure 1: The Equality Measurement Framework

Source: Adapted from Burchardt and Vizard (2011)

A key advantage of the EQLS is that it provides information on all three of these aspects of inequality. This report is not only about inequalities in outcomes between individuals and population subgroups. It is also about inequalities in perceived autonomy, for example, whether there are systematic inequalities in the extent to which individuals and population subgroups feel they are able to make critical decisions in life. Furthermore, it investigates inequalities in perceptions of treatment with dignity and respect.

Dashboard of indicators

Another way in which this report builds on the EMF is in using a dashboard of indicators to evaluate social inequalities in quality of life. An alternative approach is to use a combination of indicators across different aspects of quality of life to construct a single composite indicator or index. There are various drawbacks to the single composite indicator approach. Information in different domains is often not readily compared, and information can be lost in the process of aggregation (Eurofound, 2003, 2004). Furthermore, the limitations of composite indicators can be particularly important in the context of monitoring inequalities, where different population subgroups may be disadvantaged in relation to one indicator but not another. A dashboard of indicators approach was therefore adopted as the basis for evaluating social inequalities in this report.

Principle of systematic disaggregation

Finally, the report adheres to the EMF's key principle that all indicators should be systematically disaggregated according

to a set of agreed equality characteristics. An evidence base on social inequalities is built up against each indicator by systematically disaggregating findings according to an agreed list of disaggregation characteristics (gender, age, disability status, employment status and citizenship status).

Importantly, the principle of systematic disaggregation reflects ongoing EU data disaggregation initiatives. For example, an evaluation of the European Year for Combating Poverty and Social Exclusion 2010 (Cancedda and McDonald, 2011) highlights the fact that poverty and social exclusion data are often not even disaggregated by the first of the disaggregation characteristics considered in this report, namely, gender. The lack of disaggregated gender data was identified as an obstacle to gender mainstreaming in public policy and, more generally, to the implementation of EU poverty and social exclusion strategies.

Focus of this report: Domains, indicators and subgroups

It has not been possible in this report to build up an evidence base on all 10 of the domains listed in Figure 1, nor to cover all relevant drivers of social inequalities and all potentially relevant individual and socioeconomic characteristics. It has been necessary to be selective for a number of reasons.

- Time, resource and space constraints have meant that it has not been possible to fully exploit all the information on social inequalities that is available through the EQLS.
- The EQLS does not provide coverage of all the domains in the EMF (for example, the life domain). In other domains,

such as physical and legal security, coverage of the EQLS is only partial (for example, it does not cover experiences of personal, domestic or sexual violence).

- The EQLS has strengths in certain areas but not in others. Other data sources provide more reliable evidence on trends in employment, education and income.

Despite these limitations, this report provides important evidence on four critical domains:

- health;
- standard of living;
- productive and valued activities;
- individual, family and social life.

It uses a dashboard of 10 indicators that covers these four domains (Table 1). Findings against each indicator have been systematically disaggregated by five characteristics: gender, age, disability status, employment status and citizenship status.

In selecting domains, indicators and subgroups, consideration was given to the particular strengths of the EQLS. Current European public policy concerns and initiatives, and the equality strategies and standards discussed above, were also taken into account. In addition, the role of other potential drivers of social inequalities such as educational attainment, occupation, urban or rural location, GDP per capita, income, income inequality and social arrangements (including welfare and healthcare regimes) is discussed in the in-depth analysis for a more limited subset of indicators.

The discussion also engages with key ongoing debates on quality of life and social inequalities in broader research. For example, the role of social gradients in income, education and occupational status as drivers of health inequalities is

currently being examined as part of the European Health Review by the World Health Organization (WHO) (WHO, 2011a). The report's findings highlight the importance of social gradients of this type in the context of three key quality of life outcomes – self-rated general health, material deprivation and perceived social exclusion.

Similarly, the role of income distribution as a driver of social inequalities has been widely discussed since Wilkinson and Pickett (2009) argued that there is a basic correlation between country-level income inequality and a range of quality of life outcomes in rich countries. Other studies question the independent effects of income inequality and highlight the role of other factors such as poverty and material deprivation (see, for example, Rowlingson, 2011). The more in-depth analysis in this report engages with this broader debate.

This report also engages with broader debates about the role that public action and different social arrangements can play in promoting and supporting capabilities, including the protective role that institutions such as welfare and healthcare systems can play in times of economic shock and recession. In relation to the current crisis, there is a need for research that addresses whether welfare states and healthcare systems have performed differently in protecting capabilities and maintaining social inequality during the downturn. Similarly, looking forward to recovery, important questions arise in relation to the ways in which different social arrangements can help to promote participatory growth and the equitable advancement of capabilities for all population subgroups. Will *all* population subgroups benefit equally from the much-hoped-for recovery, or will some population groups be 'locked out' from the benefits of growth? And what role do different social arrangements and institutions play in shaping trajectories of social exclusion and inclusion of this type?

Table 1: Indicator dashboard

Domain	Indicators
Domain 1: health	Indicator 1: self-rated general health Indicator 2: mental health Indicator 3: access to healthcare
Domain 2: standard of living	Indicator 4: material deprivation Indicator 5: access to care
Domain 3: productive and valued activities	Indicator 6: informal care
Domain 4: individual, family and social life	Indicator 7: autonomy Indicator 8: dignity and respect Indicator 9: social support Indicator 10: social exclusion

These broader debates are explored here using the EQLS to examine the associations between different European welfare regimes and healthcare systems, on the one hand, and quality of life outcomes, on the other. The analysis uses the welfare regime typology developed by Whelan and Maître (2012a; see also 2010, 2012b, c), which defines six categories of welfare regime:

- type 1: social democratic;
- type 2: corporatist;
- type 3: liberal;
- type 4: southern European;

- type 5: post-socialist corporatist regime;
- type 6: post-socialist liberal regime;

The typology includes a seventh residual category.

The analysis also uses a healthcare system variable, drawing on OECD international health financing data. This classifies different healthcare systems in terms of the proportion of total health expenditure that is financed through public financing, private financing and financing through out-of-pocket payments (OECD, 2011). Initial exploratory findings using these variables are included in the more in-depth analysis in this report.

CHAPTER 2

Health

Health

The capability for good health covers physical and mental health, as well as being able to live in a healthy and safe environment with clean air and water, freedom from pollution and other hazards, and non-discrimination in access to healthcare.

Three key indicators are used in the health domain:

- Indicator 1: self-rated general health;
- Indicator 2: mental health;
- Indicator 3: access to healthcare.

Context

The European Parliament resolution on reducing health inequalities stresses the importance of equity and reducing disparities in the health status experienced by population subgroups such as older people, people with disabilities and disadvantaged migrant groups (European Parliament, 2011). The resolution recognises that there is a social gradient in health status in EU Member States and points out that health inequalities are the result of a range of economic, environmental and lifestyle-related factors as well as difficulties in accessing healthcare. It notes that population subgroups in EU countries face different barriers and that access to healthcare can sometimes be limited for economic reasons and because of the poor distribution of medical resources.

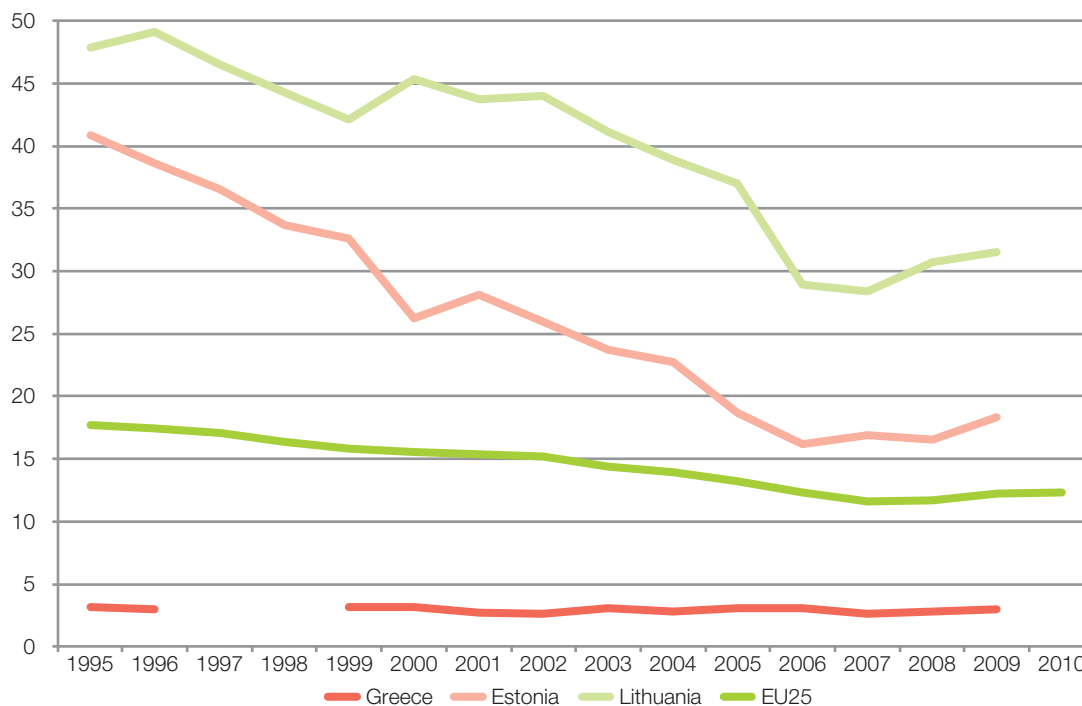
Related documents include the European Commission's statement on solidarity in health (European Commission, 2009b) and the Council's conclusions on equity and health in all policies (Council of the European Union, 2011) and on the social gradient in health and the importance of social determinants (Council of the European Union, 2010). Other recent initiatives emphasise addressing health inequalities by tackling behaviours such as poor diet, lack of physical exercise, obesity,

smoking and high alcohol consumption (see, for example, Council of the European Union, 2011).

The existence of a social gradient in favour of professional groups within Member States is a key theme in the health inequalities literature (see, for example, Mackenbach et al, 1997) and in the European Review of Health (WHO, 2011a). Building on this approach, there is increasing emphasis on the 'causes of the causes' of health inequalities, that is, on underlying social determinants and drivers such as income, education and occupational status. The need for multidimensional interventions that tackle underlying social determinants as well as healthcare access and quality is moving up the European public health agenda (see, for example, Marmot 2013).

European policies on health inequalities are summarised by Mackenbach et al (2013). The European Pact for Mental Health and Well-being recognised the prevention of depression and suicide as one of five priority areas (European Commission, 2008). While there has been a medium-term decline in suicide rates in most European countries since 1995, there is evidence of a halt in the decline and even an upturn in the rate in a number of countries, broadly coinciding with the timing of the economic crisis that began in autumn 2007 (Figure 2). It has been suggested that this indicator provided an 'early warning' of increased stress in hard-hit countries (Stuckler et al, 2011).

The overall impact of recessions on health outcomes is complex (Rhum, 2000; Avendano-Pabon, M., personal communication). However, the impact of unemployment on mental health emerges from the literature as a distinct concern, particularly for men. This issue is highlighted in recent research by the European Parliament (2012a, b).

Figure 2: Trends in suicide rates in selected European countries, 1995–2010

Notes: Age-standardised rates per 100,000 population for available years. EU25 = EU27 excluding Bulgaria and Romania

Source: OECD (2012) based on Eurostat statistics

The crisis is also having an impact on healthcare expenditure in many Member States. According to OECD analysis, growth in health spending per capita slowed or fell in real terms in 2010 in almost all European countries, reversing a trend of steady increase in many countries. Health spending per capita had already started to fall in 2009 in some of the countries hardest hit by the economic crisis (for example, Estonia and Iceland). This was followed by further and deeper cuts in 2010 in response to budgetary pressures and the need to reduce large deficits and debts. Total health spending per capita fell in Estonia, Greece and Ireland, and marked slowdowns in the rate of growth of health spending per capita occurred in a number of other countries such as Belgium, Finland, the Netherlands, Poland, Slovakia and Sweden.

In many countries severely affected by the recession, the proportion of public spending in total (public and private) healthcare financing was contained or cut, and public coverage for certain services was reduced. For example, in Ireland, the proportion of public spending in healthcare financing fell, while out-of-pocket payments increased. In contrast, in Cyprus and Norway the proportion of public spending has increased

since 2008, while in Turkey there has been an extension of public coverage for health services (OECD, 2011, 2012; Morgan and Astolfi, 2013; compare with Eurofound, in press).

Indicator 1: Self-rated general health

The EQLS collects information on self-rated health by asking individuals whether they regard their general health status as 'very good', 'good', 'bad' or 'very bad'. Women, older people, people who report having a limiting long-standing physical or mental health problem, illness or disability (referred to in this report as a 'limiting disability or health condition') and unemployed people experienced a significant disadvantage in relation to self-reported health in 2011. A higher proportion of each of these subgroups experienced bad self-reported health compared with men, younger people, people who do not report having a limiting disability or health condition, or people in work.

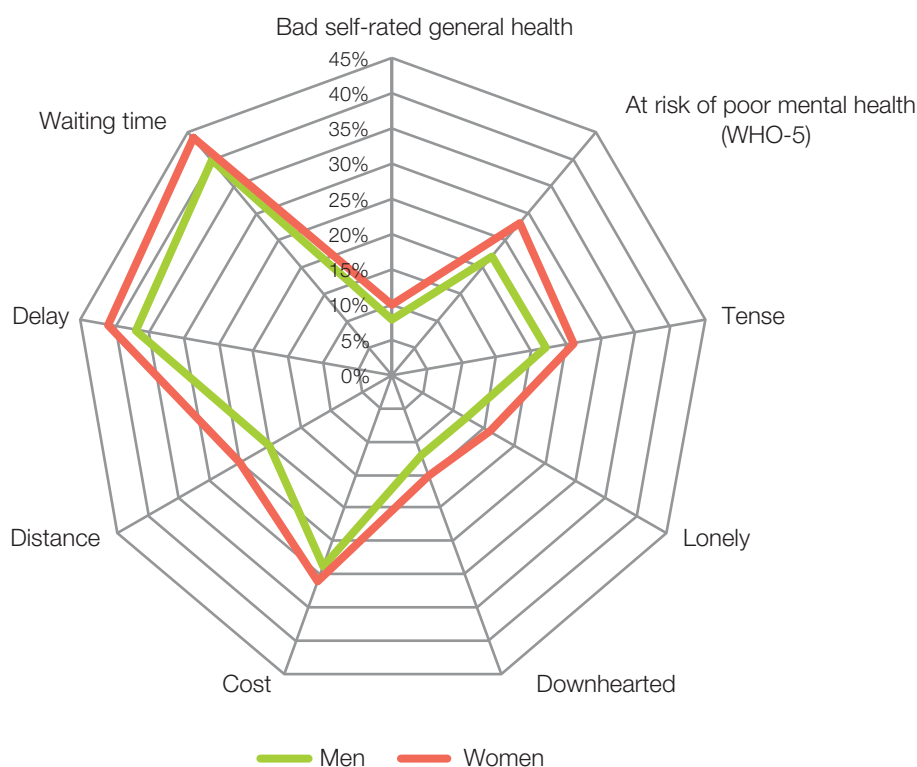
Disparities by gender

Gender inequalities are particularly marked in the health domain, with women experiencing worse health outcomes than men against all the health indicators and measures considered in this report. In 2011, women were more likely than men to report bad general health in the EU27 countries on average (10% versus 8%) (Figure 3). There was a marked difference between the 12 countries that joined the EU in 2004 and 2007 (the EU12) and the countries that were Member States prior to that enlargement. The gender gap between women's and men's self-reported health was higher in EU12 countries as a group (17% versus 11%) than in EU15 countries as a group (9% versus 7%).

Change 2007–2011

The percentage of the general population in EU27 countries reporting bad general health increased significantly, although only by 1 percentage point, between 2007 and 2011. This suggests a small decline in self-reported general health in European countries coinciding with the economic crisis. The percentage of women reporting bad self-reported health in EU27 countries increased in line with the general population increase (that is, in line with that experienced by men). While the gap between men and women did not widen over this period, the position of women, who were already disadvantaged in 2007, deteriorated further.

Figure 3: Systematic disadvantage of women in the health domain, EU27



Notes: Data points that are further out on the radar diagram indicate worse outcomes against each indicator.

Q42 In general, would you say your health is ... 1. Very good, 2. Good, 3. Fair, 4. Bad, 5. Very bad.

Q45 Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. a. I have felt cheerful and in good spirits, b. I have felt calm and relaxed, c. I have felt active and vigorous, d. I woke up feeling fresh and rested, e. My daily life has been filled with things that interest me.

Q46 Please indicate for each of the statements which is closest to how you have been feeling over the last two weeks. a. I have felt particularly tense, b. I have felt lonely, c. I have felt downhearted and depressed.

Q47 On the last occasion you needed to see a doctor or medical specialist, to what extent did each of the following factors make it difficult or not for you to do so? a. Distance to doctor's office/hospital/medical centre, b. Delay in getting appointments, c. Waiting time to see doctor on day of appointment, d. Cost of seeing the doctor, e. Finding time because of work, care for children or other.

Box 1: Risk factors and protective factors for bad self-rated general health

To examine the risk factors and protective factors associated with disadvantage in the health domain in more depth, a multilevel regression analysis was carried out using the 2011 EQLS. The analysis here is not intended to provide a full explanatory model, but rather to inform a broader and more in-depth discussion of the drivers of bad self-rated general health and as a guide to policy recommendations in this area.

Previous analysis of the 2007 EQLS showed that, after controlling for other factors, the level of educational attainment has a significant effect on self-rated general health in almost all European countries; Austria, Denmark and the Netherlands are exceptions (Schütte et al, 2013). The impact of education was also found to vary with gender. Social inequalities were higher among men than women in the Czech Republic and Lithuania; conversely, they were higher among women than men in Portugal and the EU15.

In the first stage of the modelling exercise using the 2011 EQLS, controls were introduced for gender, age, disability, economic status and citizenship. The following characteristics were found to have a significant negative association with bad self-rated general health:

- being unemployed;
- having a limiting disability or health condition;
- being in an older age band (35+).

Gender and EU non-citizenship were found not to have a significant association with self-rated health once this initial set of controls was introduced.

Examining the interaction between age group and disability, the positive association between the risk of bad self-rated health and older age was most pronounced for individuals who did not have a limiting disability or health condition.

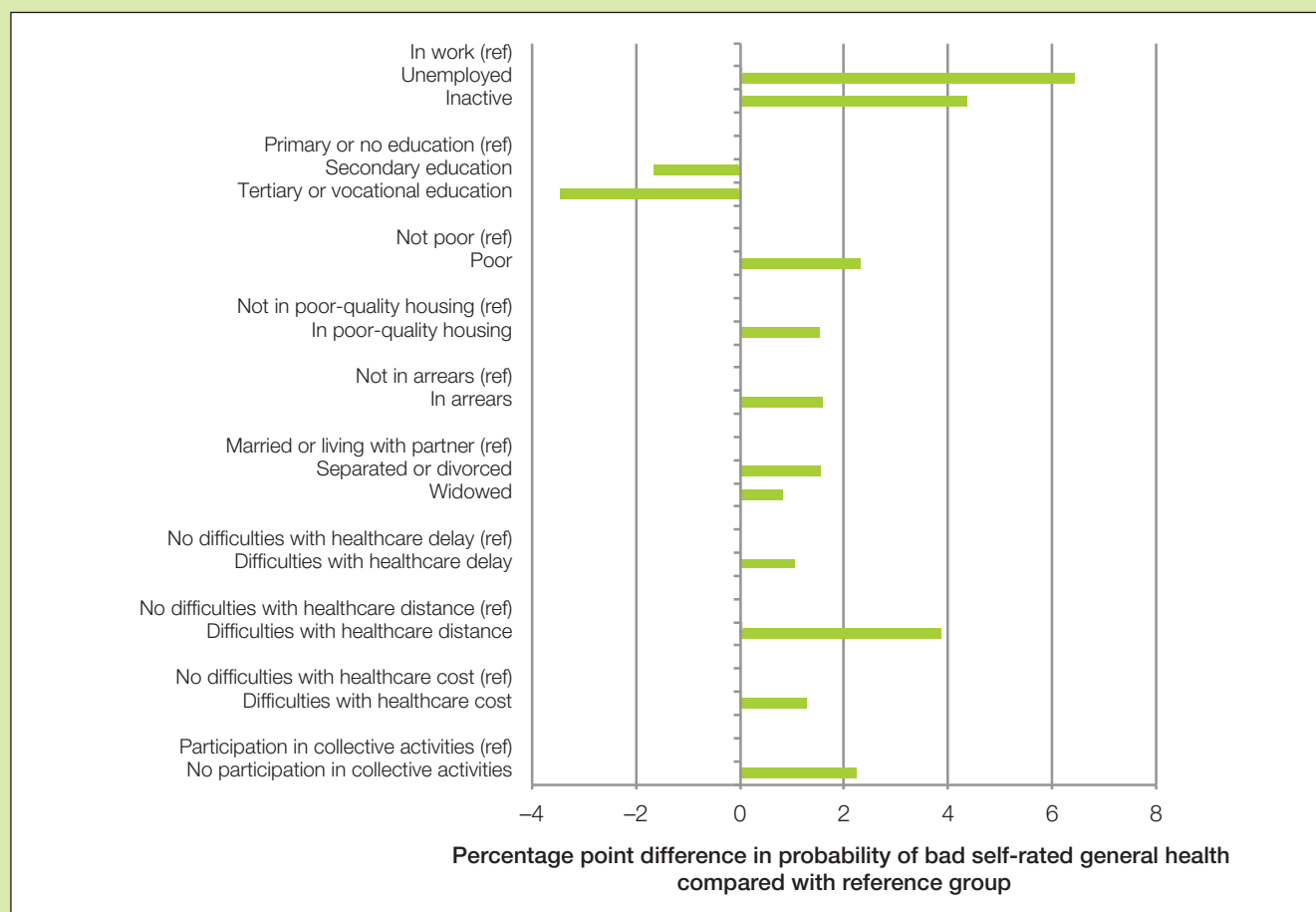
In the second stage of the modelling exercise, controls were introduced for a broader range of individual socioeconomic characteristics. The following variables were found to have a significant negative association with bad self-rated health after controlling for other factors (Figure 4):

- poverty – viewed as being income poor or experiencing severe material deprivation;
- living in poor-quality housing (shortage of space; rot, damp, leaks; no indoor flushing toilet; lack of bath or shower);
- being in arrears with, for example, rent, mortgage payments or household bills;
- having lower rather than higher educational qualifications;
- not participating in collective social activities, for example, through membership of organisations or volunteering;
- marital or partnership breakdown;
- widowhood.

Social arrangements relating to healthcare provision were observed to play an important protective role, with difficulties with healthcare costs, distance and delays in making appointments or receiving healthcare all having a significant association. No significant difference was identified in the probability of reporting bad health between urban and rural areas, or between occupational groups (apart from the 'other' category) once controls were introduced.

In the third stage of the research exercise, the association of macro variables including gross domestic product (GDP) per capita and income distribution (the Gini coefficient) with bad self-rated health was examined. The association with GDP per capita was found to be significant after controlling for other factors, meaning that country wealth has a positive effect on outcomes. The impact of income distribution was found to be insignificant, controlling for other factors.

Figure 4: Variation in the risk of bad self-rated general health, by socioeconomic characteristics, EU27



Notes: Based on multilevel logistic regression analysis; predicted probabilities based on a fixed portion of the model only. 'ref' indicates the reference group.

In further exploratory analysis, the impact of different types of healthcare system and welfare regime was considered. After controlling for other factors, healthcare system type 4 (medium private financing, medium out-of-pocket financing) was observed to be associated with bad self-rated health compared with type 1 (high public financing). Welfare regime type 2 (corporatist) and type 4 (southern European) were observed to be negatively associated with bad self-rated general health relative to type 1 (social democratic) after controlling for other factors. Welfare regime type 6 (post-socialist liberal) and type 7 (residual category) were observed to be associated with bad self-rated general health.

A number of caveats are necessary here. The findings on healthcare system type and welfare regime type in this report are intended as preliminary and exploratory. In addition, the underlying healthcare and welfare regime typologies used in this analysis have important limitations. Further research is needed on the underlying typology and sensitivity analysis in relation to the robustness of the results to changes in the typology. Ongoing processes of healthcare and welfare reform will affect the classification of different countries both in the short term (given the nature of current policy changes) and over time.

It is also important to note that welfare regime country clusters are correlated with GDP. Furthermore, welfare regime is closely linked to geographical clustering (for example, liberal, comprising Ireland and the UK; southern European; social democratic, such as Norway and Sweden); and geography is in turn linked to diet, climate, smoking, alcohol consumption and other lifestyle and behavioural factors that have an important effect on health (and which were not controlled for in the modelling exercise). For example, public health literature establishes that the southern Mediterranean diet plays a protective role, while in some Nordic countries, certain adverse health outcomes may be linked to underlying lifestyle and behavioural factors (Avendano-Pabon, M., personal communication).

Overall, the findings from the multilevel regression modelling exercise for bad self-rated health suggest that people who experience a limiting disability or health condition, unemployed people and older people are at risk. Public policy frameworks should take account of the different needs and situations of population subgroups and the particular risks among those who experience material deprivation, low income and arrears. Access to healthcare is itself a key policy lever, including the cost, distance and delay dimensions of healthcare. Non-medical determinants also play a critical role. Multidimensional health strategies that address broader drivers such as poor-quality housing and low educational attainment are also required.

Indicator 2: Mental health

The EQLS collects information on a number of aspects of mental health. This includes information using the WHO-5 Mental Well-being Index, which focuses on so-called 'positive mood states'. The WHO-5 scale ranges between 0 and 25, with a score of less than 13 indicating a risk of poor mental health and an indicator of depression. The EQLS also collects information on three 'negative mood states' – feeling tense, feeling lonely and feeling downhearted.

Mental health of older people

The European Pact for Mental Health and Well-being (European Commission, 2008) highlights the mental health of older people as a key priority. The findings in this analysis suggest that older people are at increased risk of poor mental health, with older people aged over 75 considerably more likely to experience a WHO-5 score of less than 13 than the 18–24 years age group.

Existing indicators of poor mental health may fail to fully capture older people's poor mental health since many common measures of depressive symptoms are not appropriate in old age (Avendano-Pabon, M. and Courtin, E., personal communication). For this reason, the supplementary information on feeling tense, lonely and downhearted provided by the EQLS is of particular value in building up an evidence base on older people's mental health. At the EU27 level, older people aged 81 or over and in the 75–80 age group are more likely than those aged 18–24 to report feeling lonely (27% versus 23% versus 9%) and downhearted (20% versus 18% versus 8%). The disparities are most pronounced among the 'oldest of the old', that is, those aged 81 or over.

Disparities by disability

Higher proportions of those who reported having a limiting disability or health condition also had a WHO-5 score of less than 13 as well as feeling tense, lonely and downhearted (Figure 5). This finding is in line with other studies that suggest that disabled people have higher unmet health needs than the general population (WHO, 2012).

Disparities by economic status

With unemployment, especially youth unemployment, high on the political agenda in many Member States, the health inequalities experienced by unemployed people highlighted by this analysis are a particular public policy concern.

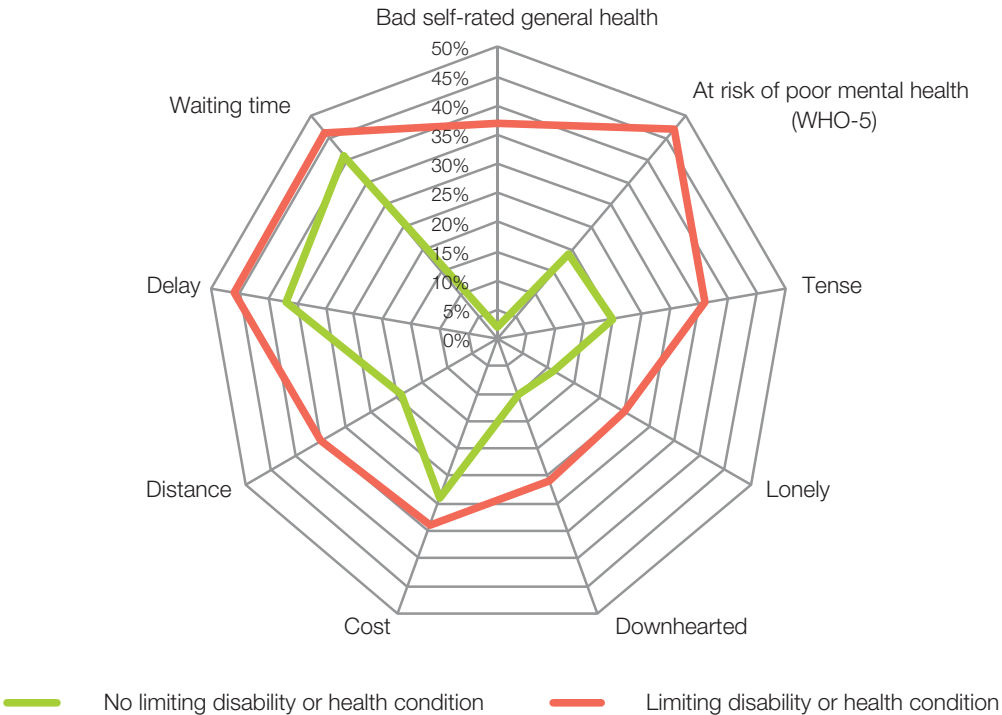
Unemployed people are systematically disadvantaged in relation to all the indicators in the health domain, with the disparities most marked between people who are employed or self-employed and the long-term unemployed (that is, those who have been unemployed for 12 months or more) (Figure 6). Patterns for the risk of poor mental health by economic status reflect this trend. Unemployed people are more likely to be identified as being at risk of poor mental health across Europe, with the disparities most pronounced for the long-term unemployed. The long-term unemployed and short-term unemployed are also more likely to report feeling tense, lonely or downhearted than those in work.

Change 2007–2011

There was no significant change in the percentage of individuals at risk of poor mental health in EU27 countries between 2007 and 2011. However, this overall average figure obscures considerable variation in the magnitude and direction of changes across different countries. Some countries – including some countries hard hit by the recession – experienced significant increases between 2007 and 2011 in the proportion of the general population identified as having a WHO-5 score of less than 13.

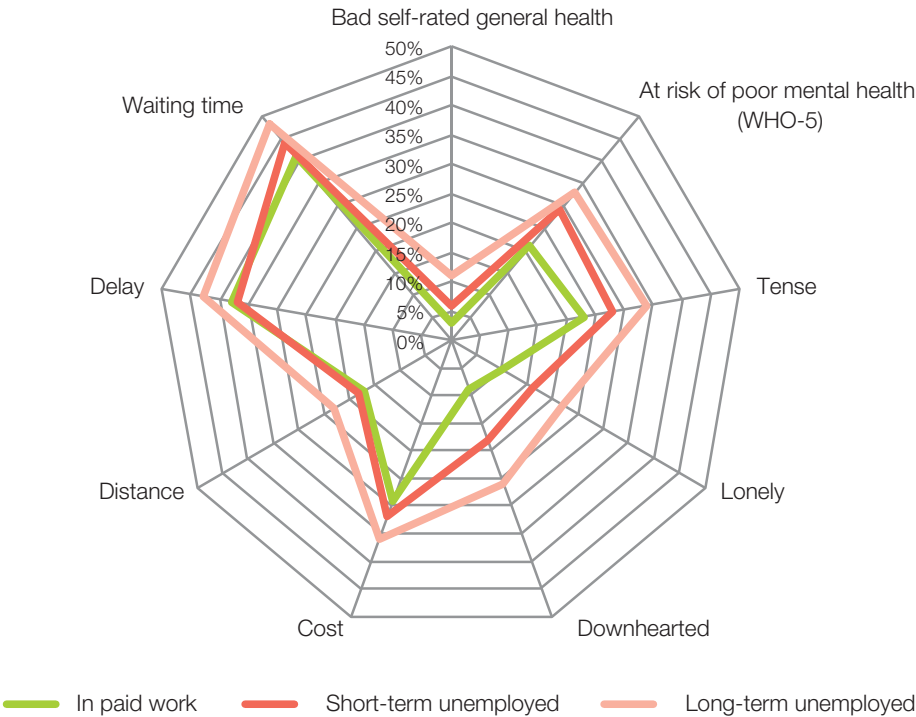
For example, there was a significant increase of 6 percentage points in the proportion of the general population identified as at risk of poor mental health in Greece (Figure 7). This finding is consistent with evidence from the literature that suggests that the economic crisis has had a severe negative impact on health outcomes in Greece. An increase in suicides has been reported (Stuckler et al, 2011), and there is evidence that self-reported health, mental disorders, suicides, access to healthcare, HIV infections, violence and homicide worsened in Greece in the wake of the crisis (Kentikelenis et al, 2011; Karanikolos et al, 2013; Vandonos et al, 2013).

Figure 5: Systematic disadvantage in the health domain of people with a limiting disability or health condition, EU27



Notes: Data points that are further out on the radar diagram indicate worse outcomes against each indicator. The severity of disadvantage against different indicators is not necessarily comparable.
Q42, Q45, Q46 and Q47 (see Figure 3 for wording)

Figure 6: Systematic disadvantage in the health domain of unemployed people, EU27



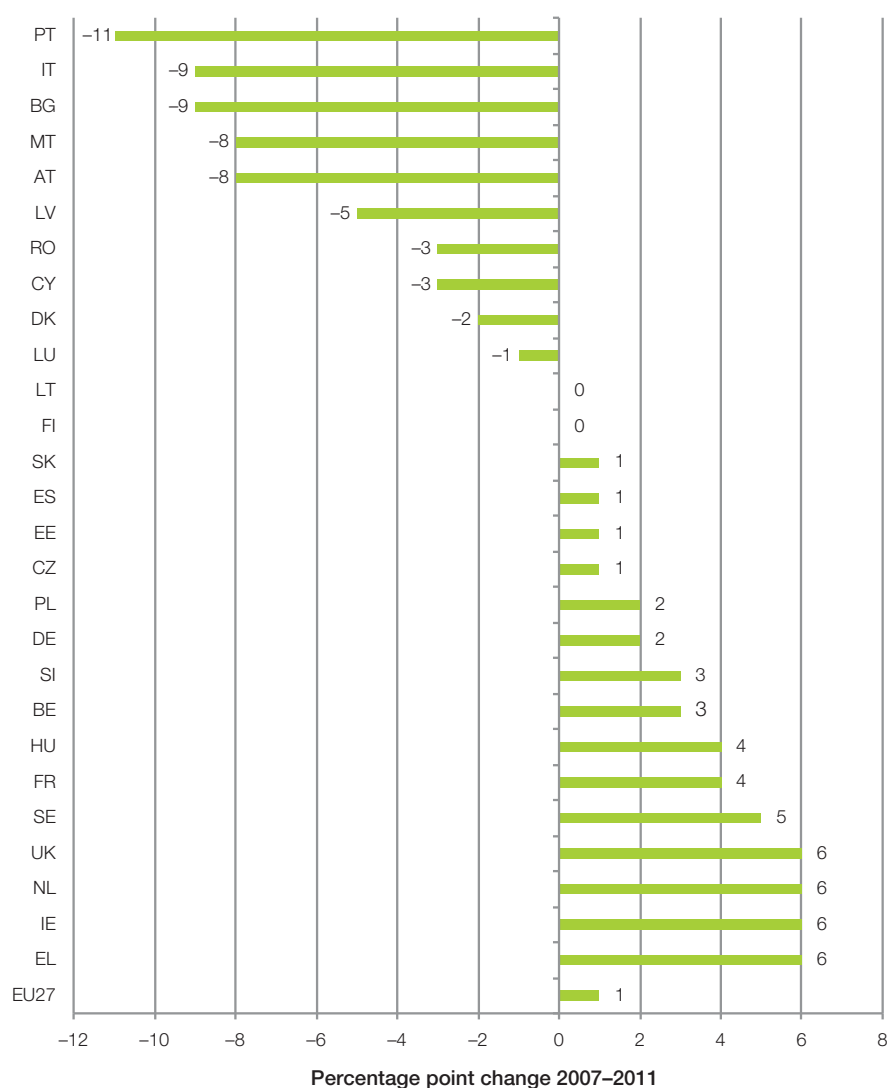
Notes: Data points that are further out on the radar diagram indicate worse outcomes against each indicator.
Q42, Q45, Q46 and Q47 (see Figure 3 for wording)

At the EU27 level, the most marked significant increases among different population subgroups in the percentage indicating for WHO-5 depression are among 18–24-year-olds (by 3 percentage points) and 50–64-year-olds (by 2 percentage points). As already noted, unemployment is often regarded as a risk factor for increased likelihood of poor mental health, particularly among men. The findings here are in line with other research evidence highlighting the severe adverse effects of the economic downturn on young people in many EU27 countries. The findings suggest that these severe adverse effects on young adults are not limited to employment and income, but also extend into other critical areas of life, with far-reaching impacts on socio-psychological stress and mental health.

The negative health consequences of the economic downturn can be mitigated by public action. Although it might be anticipated that the economic crisis will produce secondary mental health effects including increased suicide and alcohol death rates, such effects can be offset by social welfare and public policy (WHO, 2011b). Options highlighted include:

- active labour market programmes aimed at helping people retain or find jobs;
- family support programmes;
- higher alcohol prices;
- debt-relief programmes;
- accessible and responsive primary care services.

Figure 7: Change in the percentage of the population at risk of poor mental health between 2007 and 2011, by country



Note: Q42, Q45, Q46 and Q47 (see Figure 3 for wording)

Box 2: Distribution of satisfaction with health and mental well-being

Satisfaction with health is one of a suite of subjective measures of well-being included in the EQLS. In the EU27, the 20% of the population with the lowest health satisfaction (quintile 1) had an average health satisfaction of 3.6 out of 10. The 20% with the highest health satisfaction (quintile 5) had an average score of 9.7. There was considerable variation in the distribution of health satisfaction at the individual country level. For example, in the Netherlands the distribution ranged from an average health satisfaction score of 4.4 in quintile 1 to an average score of 9.6 in quintile 5. In Cyprus, the quintile distribution was higher, ranging from 4.7 to 10. However, in Estonia, the distribution ranged from 2.6 in quintile 1 to of 9.7 in quintile 5.

At the EU27 level, the WHO-5 Mental Well-being Index varied from an average score of 7.6 in quintile 1 to an average score of 21.8 in quintile 5. Again, higher scores and greater disparities across quintiles were apparent for individual countries. For example, in the Netherlands, the distribution ranged from an average score of 8.8 in quintile 1 to an average score of 21.7 in quintile 5. In Slovakia, the distribution ranged from 6.8 to 21.5, while in the UK, it ranged from 6.2 to 21.5.

Indicator 3: Access to healthcare

The EQLS collects information on people's experiences in accessing and using healthcare, including difficulties with cost, distance, delay and time.

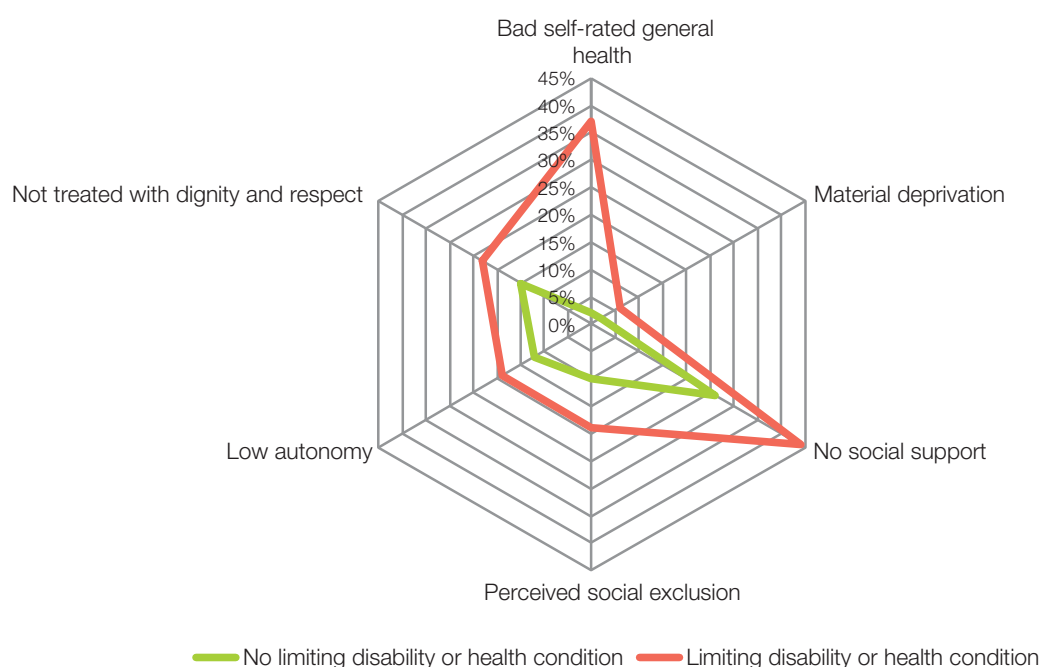
Disparities by disability

Disparities in access to healthcare for those who report having a limiting disability or health condition are pronounced in both

the EU15 and EU12 groups of countries. Those with a limiting disability or health condition are more likely to report difficulties with all aspects of access to healthcare.

The WHO factsheet on disability and health recommendations for removing barriers and improving the accessibility of health-care services to people with disabilities has both financial and service delivery dimensions (WHO, 2012). In relation to financial barriers, the WHO recommends that options are considered for reducing or removing out-of-pocket payments for people with disabilities who do not have other means of financing healthcare

Figure 8: Systematic disadvantage of people with a limiting disability or health condition, EU27



Notes: Data points that are further out on the radar diagram indicate worse outcomes against each indicator. The severity of disadvantage against different indicators is not necessarily comparable.

services. Where private health insurance is important, it is important to ensure that people with disabilities are covered and that measures are considered to make premiums affordable.

This second recommendation relates to EU equality initiatives that aim to extend non-discrimination protection to cover additional areas such as goods and services.

In terms of improving physical accessibility, the WHO factsheet recommends a broad range of modifications and adjustments (reasonable accommodation) to facilitate access to healthcare services. Examples include changing the physical layout of clinics to provide access for people with mobility difficulties or communicating health information in accessible formats such as Braille.

People who experience a limiting disability or health condition are systematically disadvantaged across the various domains and indicators considered in this report (Figure 8). Further research is required to look into this issue in more depth.

Disparities by citizenship

Concerns about the access of non-EU citizens to healthcare are moving up the European public policy agenda. For example, there are signs of lack of access to antenatal care, vaccinations and primary healthcare both for non-EU nationals in the EU27 and EU nationals living in other EU countries (Chauvin and Mestre, 2012; Watson, 2012). Barriers to healthcare access include:

- poor understanding of rights and healthcare systems;
- administrative problems (relating to documentation);
- language barriers.

The EQLS data point towards a mixed picture, with non-EU citizens reporting lower levels of difficulty with delay and time than EU citizens, but greater difficulties with cost and distance.

Health inequalities experienced by migrants, asylum seekers and illegal immigrants are recognised in the European Parliament's health inequalities resolution (European Parliament, 2011), the European Health Review (WHO, 2011a) and the European Pact for Mental Health and Well-being

(European Commission, 2008). The barriers of access these groups face include:

- restrictions on rights to access to emergency and medically necessary healthcare;
- lack of insurance coverage;
- fear of extradition (for illegal immigrants).

A forthcoming Eurofound report on the impact of the crisis on access to healthcare services will further extend the evidence base.

Change 2007–2011

There was a fall at the EU27 level between 2007 and 2011 in the proportion of individuals reporting each of the four categories of difficulty in accessing healthcare (cost, distance, delay and time). This overall average figure again obscures considerable variations in the patterns of overall change at the individual country level.

For example, in Greece, the percentage reporting difficulties with cost increased from 45% to 64% (+19 percentage points); the percentage reporting difficulties with distance increased from 24% to 45% (+21 percentage points); the percentage reporting difficulties with delays increased from 43% to 67% (+24 percentage points); and the percentage reporting difficulties with waiting times increased from 47% to 66% (+19 percentage points).

In addition to variations across Member States, there were different trends between 2007 and 2011 among different population subgroups. There were reductions in difficulties accessing healthcare for women, people who have a limiting disability or health condition, older people and unemployed people. However, the rates of improvement for these population subgroups were not all as rapid as for the general population and, in this sense, gaps widened and social inequalities increased.

Older age groups and people with a limiting disability or health condition also experienced smaller reductions in difficulties accessing and using healthcare than were experienced in the general population.

CHAPTER 3

Standard of living

Standard of living

The capability to enjoy an adequate and secure standard of living includes having secure access to adequate nutrition, clothing, housing, warmth, social security, social services, utilities and transport. Findings for this domain are reported here against two indicators: material deprivation (Indicator 4) and access to care (Indicator 5).

Context

One of the five headline targets of the Europe 2020 strategy is to lift at least 20 million people out of the risk of poverty or social exclusion by 2020. Progress towards the target is monitored by Eurostat through European Union Statistics on Income and Living Conditions (EU-SILC) data using a composite indicator covering risks of income poverty, material deprivation and living in a household with low work intensity.

The following conclusions can be drawn from Eurostat statistics on people at risk of poverty or social exclusion (Eurostat, 2013b).

- A total of 119.6 million people, or 24.2% of the population, in the EU27 were at risk of poverty or social exclusion in 2011, compared with 23.6% in 2010.
- Some 16.9% of the EU27 population was at risk of income poverty after social transfers in 2011. This means they were living in a household with an equalised disposable income below the risk of poverty threshold (set at 60% of the national median equalised disposable income after social transfers). This was a 0.5 percentage point increase compared with 2010.
- There were considerable variations across EU Member States in at-risk poverty rates, with the highest rates observed in Bulgaria, Greece, Romania and Spain. The risk of poverty increased most in Bulgaria, Estonia and Hungary between 2010 and 2011, with rises also observed in Greece, Italy and Spain. Social transfers had an important redistributive impact and resulted in a considerable reduction in the number of people at risk of poverty.
- Severe material deprivation (defined using EU-SILC data as the proportion of people who cannot afford four out of nine listed items) was experienced by 8.5% of the EU27 population, with rates of more than 30% in Bulgaria and Latvia, and more than 20% in Hungary and Romania. The overall EU severe material deprivation rate increased by 0.5

percentage points between 2010 and 2011, with sharper increases in Greece, Italy and Latvia.

The impact of the downturn on income distribution up to 2009 depended on who was affected and their location in the distribution at the onset of the crisis (Jenkins et al, 2011). A number of countries were able to cushion households from the immediate effects of the crisis by means of benefits and other social safety nets. For example, in Ireland strong social transfers had a notable countervailing effect, with income inequality declining slightly between 2007 and 2009 and the relative poverty rate falling from 20% to 18%. However, Italy was one of two case study countries (along with the USA) where increases in income inequality and in relative poverty were more apparent (Jenkins et al, 2011). The authors predicted that, in the medium to longer term, as governments cut public spending and raise taxes to confront structural deficits, household incomes could be hit for periods of up to 5 or 10 years or even longer.

Avram et al (2013) used the EU micro-simulation model EURO-MOD to compare the distributional effects of policy changes presented as fiscal consolidation measures in nine EU countries that had experienced large budget deficits following the economic crisis (that is, Estonia, Greece, Italy, Latvia, Lithuania, Portugal, Romania, Spain and the UK). These countries adopted different policy mixes to achieve varying degrees of fiscal consolidation. A key finding is that the burden of fiscal consolidation brought about through the first round effects of increases in personal taxes, cuts in spending on cash benefits and reductions in public sector pay was shared differently across the income distribution in these nine countries. For example, in Greece, Italy, Latvia, Romania, Spain and the UK, the better-off lost a higher proportion of their incomes than the poor. In Estonia, however, the poor lost a higher proportion than the rich.

Indicator 4: Material deprivation

An initial evidence base for material deprivation is provided in the third EQLS overview report (Eurofound, 2012b, pp. 42–45). The EQLS collects information on material deprivation across six items, with respondents asked whether they can afford to:

- keep their house adequately warm;
- pay for a week's annual holiday away from home (not staying with relatives);

- replace worn-out furniture;
- have a meal with meat, chicken or fish every second day if they wanted it;
- buy new rather than second-hand clothes;
- have friends or family for a drink or meal at least once a month.

This report looks at social inequalities as measured by the inability to afford all six items – referred to as ‘severe material deprivation’.

An important advantage of the EQLS evidence base on material deprivation is that it supports disaggregation by a broad range of characteristics beyond that provided by the EU-SILC data. A summary of disaggregated findings on severe material deprivation is presented in Table 2. Having a limiting disability or health condition, being older, being unemployed and being a non-EU citizen all stand out as being associated with experiencing deprivation in all six items listed above. The position of those who report a limiting disability or health condition, older people, unemployed people and non-EU citizens is systematically worse than

Table 2: Comparison of severe material deprivation across population subgroups

Characteristic	Subgroup	Deprivation (all items) (%)		
		EU27	EU15	EU12
Gender	Male	3	2	7
	Female	3*	2	8*
Disability	No limiting disability or health condition	2	2	5
	Limiting disability or health condition	6*	3*	15*
Age group	18–24 years	2	2	2
	25–34 years	3	2	5
	35–49 years	2	2	6*
	50–64 years	4*	3	10*
	65–74 years	4*	2	12*
	75–80 years	4*	2	15*
	81+ years	3*	2	11*
Economic status	Employee, employer or self-employed	1	1	3
	Unemployed less than 12 months	6*	6*	9*
	Unemployed 12 months or more	11*	7*	26*
	Unable to work due to long-term illness	11*	8*	18*
	Retired	4*	2*	11*
	Full-time homemaker	4*	3*	10*
Citizenship	EU citizenship	3	2	7
	Non-EU citizenship	4*	4*	8*

Notes: For each population subgroup, the reference group is highlighted in bold. * = statistical significance of difference from reference group at the 5% significance level and has been tested using a one-variable logistic regression test. Rounding of values has made significant male–female difference at the EU27 level not apparent.

Q59 There are some things that many people cannot afford, even if they would like them. For each of the following things on this card, can I just check whether your household can afford it if you want it? a. Keeping your home adequately warm, b. Paying for a week’s annual holiday away from home (not staying with relatives), c. Replacing any worn-out furniture, d. A meal with meat, chicken, fish every second day if you wanted it, e. Buying new, rather than second-hand, clothes, f. Having friends or family for a drink or meal at least once a month.

for comparator subgroups (people who do not have a limiting disability or health condition, people in work and EU citizens). The picture by gender is more mixed, with women disadvantaged relative to men in EU12 countries but not in EU15 countries.

Disparities by disability

Disabled people are among the most marginalised population subgroups across the EU and are often at risk of poverty and material deprivation (Zaidi, 2011), even though many European countries have social benefits that protect their income. In recent years, there has been a substantial increase in the number of younger people with health problems accessing disability benefits across the EU (Eurofound, 2010a).

The analysis of data from the third EQLS suggests that disparities in severe material deprivation are particularly marked among those who have a limiting disability or health condition. In both EU12 and EU15 countries, those with a limiting disability or health condition are more likely to report being deprived in all six categories. Both the proportion of people with disabilities who experience material deprivation, and the relative gaps between people with disabilities and people without, are more pronounced in EU12 than in EU27 countries as a whole.

In EU27 countries, on average, 6% of people who report having a limiting disability or health condition also report material

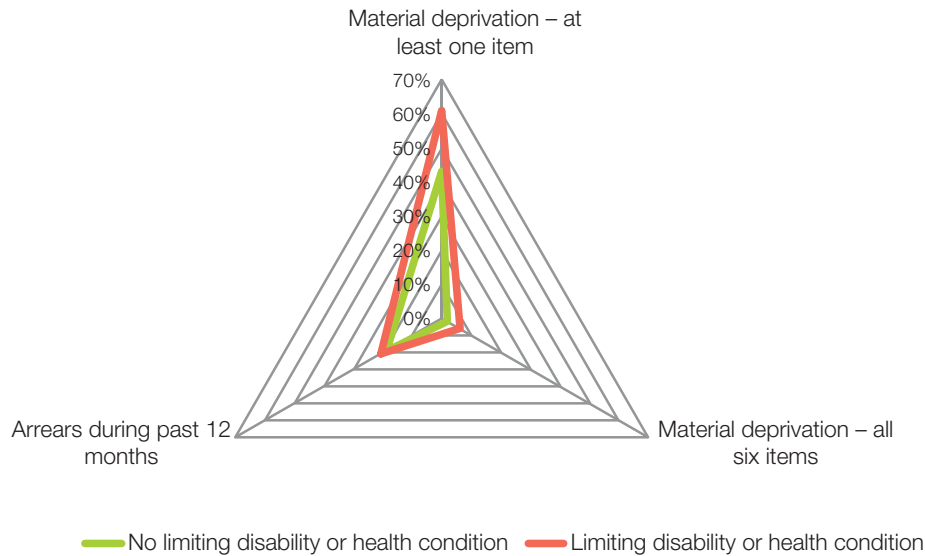
deprivation in all six items compared with 2% of those with no limiting disability or health condition – a gap of 4 percentage points. Both deprivation levels and social inequalities are higher in EU12 countries, where 15% of individuals who report having a limiting disability or health condition report being unable to afford all six items. This compares with 5% of those with no limiting disability or health condition – a gap of 10 percentage points.

Similar patterns of deprivation and social inequalities for people with disabilities are observed for those who are unable to afford at least one of the items, and in relation to other aspects of financial difficulty such as problems with arrears and debt (Figure 9). The third EQLS asked respondents whether they had experienced difficulties with:

- scheduled payments for rent or mortgage payments for accommodation;
- utility bills such as electricity, water and gas;
- payments related to consumer loans, including credit card overdrafts (to buy electrical appliances, a car, furniture and so on);
- payments related to informal loans from friends or relatives not living in their household.

People with disabilities are also more likely to experience disadvantage against these measures.

Figure 9: Systematic disadvantage in the standard of living of people with a limiting disability or health condition, EU27



Notes: Data points that are further out on the radar diagram indicate worse outcomes against each indicator. The severity of disadvantage against different indicators is not necessarily comparable.
Q59 (see Table 2 for wording)

Disparities by economic status

Material deprivation among unemployed people in Europe is a particular concern following the economic crisis. At the EU27 level, the unemployed are significantly more likely to experience material deprivation than their counterparts in work (employees, employers and self-employed), with the disparities most pronounced for the long-term unemployed. Again, both deprivation levels among the unemployed and relative gaps between them and those in work are highest in EU12 countries.

In EU27 countries, on average, 6% of short-term unemployed people and 11% of long-term unemployed reported in the third EQLS being unable to afford all six items compared with 1% of those in work – gaps of 5 and 10 percentage points respectively (Figure 10). Both deprivation levels and social inequalities were higher in EU12 countries, where 9% of the short-term unemployed and 26% of the long-term unemployed reported being unable to afford all six items compared with 3% of those in work – gaps of 6 and 23 percentage points respectively compared with those in work.

Risk in older age

People aged 65 or over faced a lower risk of poverty or social exclusion in 2011 than the overall population both at EU27

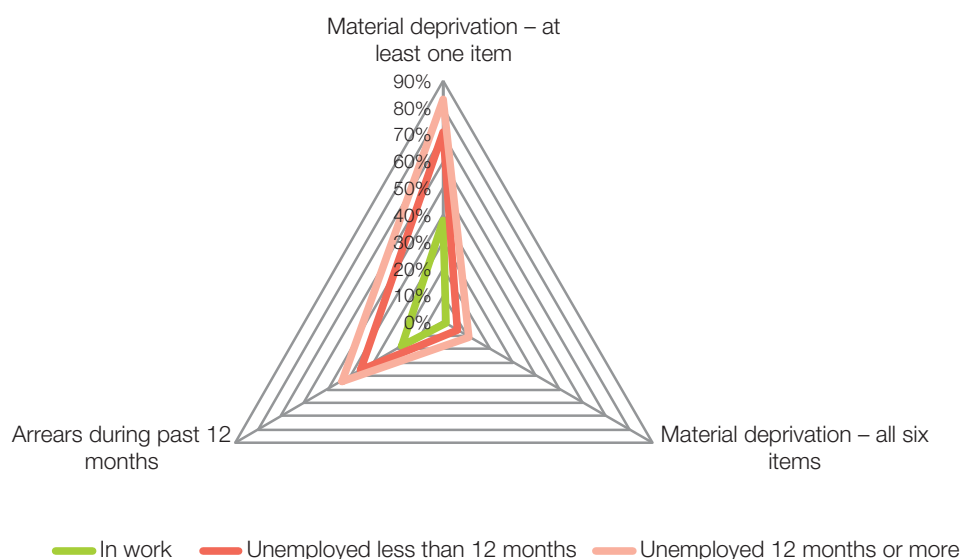
level and in 16 of the 26 countries with available data (Eurostat, 2013b). However, the risk of poverty or social exclusion faced by this age group in 2011 ranged from 4.7% in Luxembourg to 61.1% in Bulgaria, depending on factors such as the pension system and the age and gender structure of the elderly population. Elderly women and the very old faced much higher risks in some countries.

The findings presented in Table 2 suggest that, on average, a higher proportion of individuals over 50 years old experience severe material deprivation than their younger counterparts in EU27 countries. Material deprivation in older age stands out as a particular concern in EU12 countries, where the proportion of materially deprived people rises with age continuously up to the 75–80 age group before falling back.

Risk among EU non-citizens

Eurostat (2013b) draws attention to children's high risk of income poverty. There are subgroups of children for whom the risks are even higher, such as those with migrant parents. The analysis using data from the third EQLS suggests that a higher proportion of non-EU citizens experience severe material deprivation, with the disparities with EU citizens more marked in EU15 countries.

Figure 10: Systematic disadvantage in standard of living of unemployed people, EU27



Notes: Data points that are further out on the radar diagram indicate worse outcomes against each indicator. The severity of disadvantage against different indicators is not necessarily comparable.

Q59 (see Table 2 for wording)

Box 3: Distribution of material deprivation in the EU

In the EU27, the 20% of the population with the lowest average material deprivation score (quintile 1) had an average score of 0; the 20% with the highest average score (quintile 5) had an average score of 4.6. There was considerable variation in the distribution of material deprivation at the individual country level. For example, in Sweden and the Netherlands inequality is relatively low. In Sweden, the distribution ranges from an average material deprivation score of 0 in quintile 1 to an average score of 2.3 in quintile 5. In the Netherlands, the distribution ranges from 0 in quintile 1 to 2.5 in quintile 5. Other countries with low inequality include Austria and Luxembourg. In contrast, in Estonia inequality is much higher, with the average material deprivation score ranging from 0.1 in quintile 1 to 6 in quintile 5. Similarly in Greece, the range is from 0 to 5.7.

Change 2007–2011

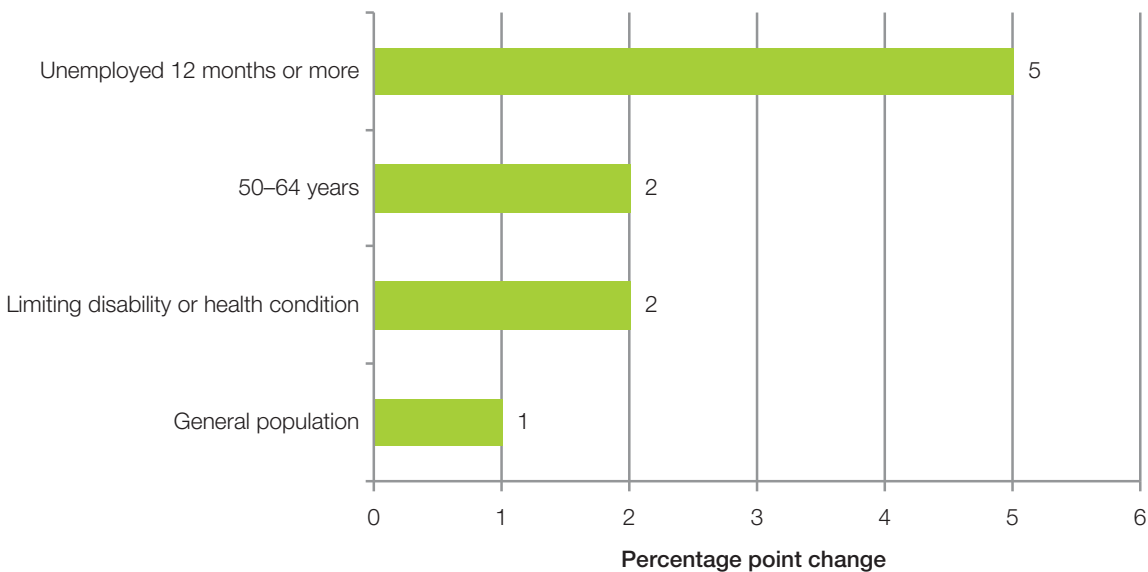
How has the proportion of the population experiencing severe material deprivation changed in the wake of the economic crisis? Overall, the proportion of individuals reporting being unable to afford all six items increased by 1 percentage point between 2007 and 2011.

The deterioration in living standards in countries hard hit by the crisis has been particularly severe. In Greece, the proportion of individuals in work reporting that they are cannot afford at least

one item increased from 48% to 74% (26 percentage points) between 2007 and 2011. For the unemployed in Greece, the prevalence rates in 2011 were even higher.

While the EQLS evidence points towards general increases in material deprivation in the European population as a whole, some population subgroups appear to have been particularly hard hit. Above-average increases were experienced by those who have a limiting disability or health condition (up 2 percentage points), the long-term unemployed (up 5 percentage points) and 50–64-year-olds (up 2 percentage points) (Figure 11).

Figure 11: Change in the percentage of people reporting severe material deprivation in EU27, by selected subgroup, 2007–2011



Notes: Q59 (see Table 2 for wording)

Box 4: Risk factors and protective factors for material deprivation

To examine the risk factors and the protective factors associated with disadvantage in the standard of living domain in more depth, a multilevel analysis was undertaken using the 2011 EQLS. As noted already, this type of analysis is not intended to provide a full explanatory model, but rather to inform discussion of the drivers of material deprivation and policy recommendations in this area.

Other studies on this subject include work by Whelan and Maître, who examined the drivers of material deprivation in 28 European countries using 2009 EU-SILC data. They identified six distinct dimensions of deprivation and identified a range of socioeconomic factors that accounted for a substantial proportion of between-country and within-country variance. However, they found that the addition of macroeconomic factors such as average levels of disposable income and income inequality contributed relatively little in the way of explanation. Significant interactions between socioeconomic factors and gross national disposable income per capita were also identified. The impact of socioeconomic differentiation was found to be significantly greater where average income levels were lower. Whelan and Maître suggested that an emphasis on the primary role of income inequality to the neglect of differences in absolute levels of income may be misleading in several respects (Whelan and Maître, 2012a, p. 7; compare with Whelan and Maître, 2010, 2012b).

In the first stage of the modelling exercise, controls were introduced for gender, age, disability, economic status and citizenship. The following factors were found to have a significant association with material deprivation:

- being female;
- having a limiting disability or health condition;
- being unemployed;
- being a non-EU citizen;
- being in an older age band rather than the youngest age band.

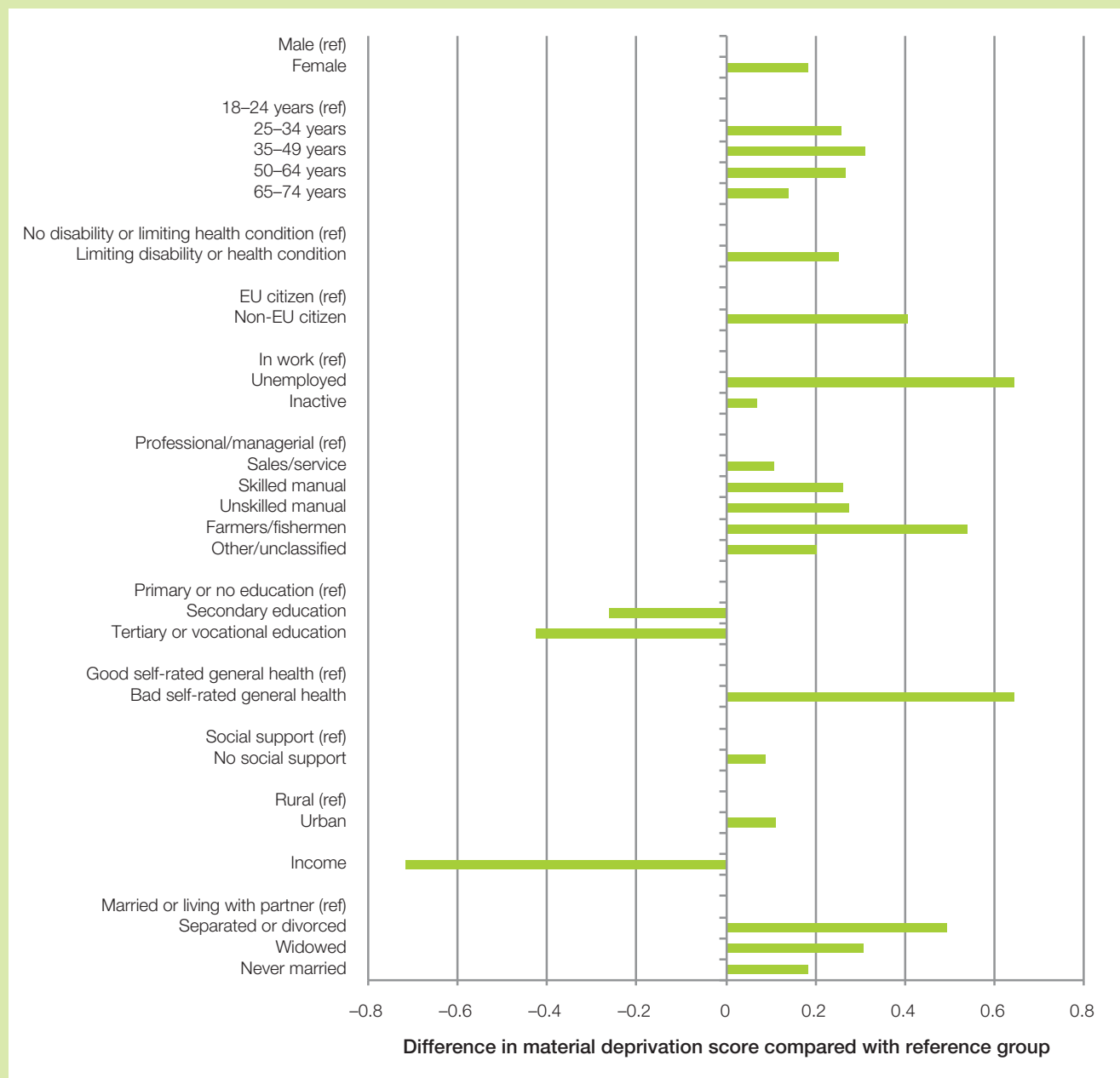
In the second stage of the modelling exercise, controls were introduced for a broader range of individual socioeconomic characteristics. The following variables were found to have a significant association, after controlling for these factors (Figure 12):

- living in a household with lower rather than higher income;
- being in a non-professional or non-managerial occupational group;
- having lower rather than higher educational qualifications;
- being widowed and not living with a partner;
- marital or partnership breakdown;
- having bad self-rated general health;
- having no source of social support;
- living in an urban area.

In the third stage of the analysis, the association of macro-variables including GDP per capita and income distribution (Gini coefficient) with material deprivation were examined. GDP per capita was found to have a significant negative association with material deprivation. The impact of income distribution was not found to be significant.

In further exploratory analysis, the impact of different types of welfare regime was examined. The caveats highlighted in Box 1 should be noted here. Welfare regime type 4 (southern Mediterranean), type 5 (post-socialist corporatist regime) and type 6 (post-socialist liberal) were observed to be associated with material deprivation relative to welfare regime 1 (social democratic welfare regime) after controlling for other factors.

Overall, the findings from the modelling exercise for material deprivation highlight the importance of mainstreaming gender and disability in public policy frameworks to address material deprivation. With high unemployment in some EU Member States, addressing material deprivation among unemployed people emerges as a key public policy concern. Among older people, Member States should address the needs and situations of widows and older people with no sources of social support within their general policy frameworks for combating material deprivation.

Figure 12: Variation in the risk of material deprivation, by socioeconomic characteristics, EU27

Notes: Based on multilevel regression analysis; marginal effects based on a fixed portion of the model only. Average material deprivation scale ranges from 0 to 6. 'ref' indicates reference group. Income does not have a reference group because it has been captured as a continuous variable; the effect can be interpreted as the change per unit increase in income.

Indicator 5: Access to care

The concept of living standards is broader than income alone or even material deprivation. For many individuals and sub-groups, access to public services, alongside income and material deprivation, is a critical determinant of their ability to enjoy an adequate standard of living. This section looks at access to formal care services.

Long-term care

The OECD characterises long-term care services as providing care for people needing support in facets of living over a prolonged period of time, including people with disabilities and the elderly (OECD, 2011, p. 162). According to an OECD analysis, the vast majority of recipients of long-term care are over 65 years of age. Women are a key user group due to their higher life expectancy combined with a higher prevalence of disabilities and functional limitations in old age. People with Alzheimer's disease and other dementias are another high user group of long-term care services in many European countries (OECD, 2011, p. 168).

Across the EU, long-term care needs are increasingly recognised as a 'social risk' that public welfare systems must address. Most western European countries have now established a funded formal long-term care system. In some countries, the long-term care system is based on social insurance principles (for example, Germany and the Netherlands), whereas in other countries the system is universalistic or quasi-universalistic ('quasi' because there are regional differences in the entitlements, such as in Sweden and the UK).

Long-term care services are differentiated in relation to (OECD, 2011; Trydegard and Thorslund, 2011):

- the degree of centralisation versus decentralisation of services;
- the use of targeting (with reform programmes that concentrate entitlements on those in greatest need under way in some Member States);
- the extent to which new programmes are being developed whereby long-term care services are accessed in the home rather than in an institutional setting.

In many EU12 countries (particularly those in eastern Europe such as the Czech Republic, Hungary, Romania, Slovakia and Slovenia), public funding of long-term care is scarce. Long-term care provision in this context is largely a family responsibility, characterised by social assistance orientation, a limited availability of formal care services that are skewed largely towards residential care, and huge regional disparities (Österle, 2010; see also Chapter 4).

A key objective of the Europe 2020 strategy is to develop more efficient health, long-term care and social services for ageing populations to support social inclusion of older people (Parent, 2012). Population ageing is a key long-term challenge for all European countries, although its magnitude, speed and timing varies with longevity gains combined with lower fertility, resulting in rising demographic dependency ratios in most Member States (see Zaidi, 2012a).

The most notable rises over the period 1960–2010 were for Germany and Italy, where the ratio almost doubled to about 31%. However, staggering increases are projected for the EU27 area as a whole from 25% in 2010 to 53% in 2060; and projected rises in eastern European countries belonging to the EU12 are especially marked. The ratio in Poland is predicted to rise from one of the lowest in 1960 (at 9.5%) to one of the highest in 2060 (65%), with similar drastic rises anticipated in other countries in the region such as Latvia, Romania and Slovakia (Eurostat, 2010a). The budgetary implications of these trends, combined with further downward pressures associated with the economic crisis, are highlighted in the European Commission's ageing report (European Commission, 2012b).

Crucial public policy challenges relate to the coverage and accessibility of long-term care services, with unmet need for social care a major concern in many Member States. Other concerns are the quality of long-term care and associated problems of substandard care and poor regulation (OECD, 2011). More generally, concerns are frequently raised over (Costa-Font, 2011):

- the longer-term affordability of the long-term social care systems;
- the fairness of the funding systems currently in place (whether private, social insurance based or universal);
- the adequacy in terms of coverage of these systems to a diverse group of older people;
- how best to contain costs over the short term during the current economic downturn.

The analysis using EQLS data confirms the far-reaching challenges ahead. At the EU27 level, 42% of individuals rated long-term care services as 'lower quality' rather than 'higher quality' in 2011. The figure was lower at the EU15 level (37%) but increased to 61% for EU12 countries. There is considerable variation between countries with Bulgaria (82%), Greece (69%), Poland, Romania and Slovakia (all 65%) performing particularly badly in terms of public perceptions of long-term care services. In only five countries (Austria, Belgium, Luxembourg, Malta and the Netherlands) were services rated poorly by less than 25% of respondents.

Quality ratings were lower for women than for men in EU15 countries; there was no gender difference in EU12 countries. There is a clear trend for individuals with a limiting disability or health condition to rate the quality of long-term care services as worse than those with no limiting condition in both EU15 and EU12 countries. As noted by Eurofound (2012b), quality ratings by older people – a key user group – were less negative in the third EQLS than those of younger age groups. In understanding this figure, it is important to note that older people's evaluations of public services can be affected by so-called adaptive expectations and gratitude bias.

High proportions of users of long-term care, including users who have a limiting disability or health condition and older users, reported difficulties with the services that they receive. At the EU27 level, 57% of users of long-term care services who have a limiting disability or health condition reported difficulties with cost, 59% with availability, 47% with access and 40% with quality. Of users aged 81 or over, 49% reported experiencing difficulties with cost, 42% difficulties with availability, 39% difficulties with access and 28% difficulties with quality (Figure 13).

The high prevalence of intense caring activities in some countries underlines a key concern raised by the OECD – namely, that a greater share of people providing informal care may be required to provide high-intensity care in the future. Policy

frameworks that recognise and address this trend will increasingly be required. According to the OECD (2011), the drivers here include:

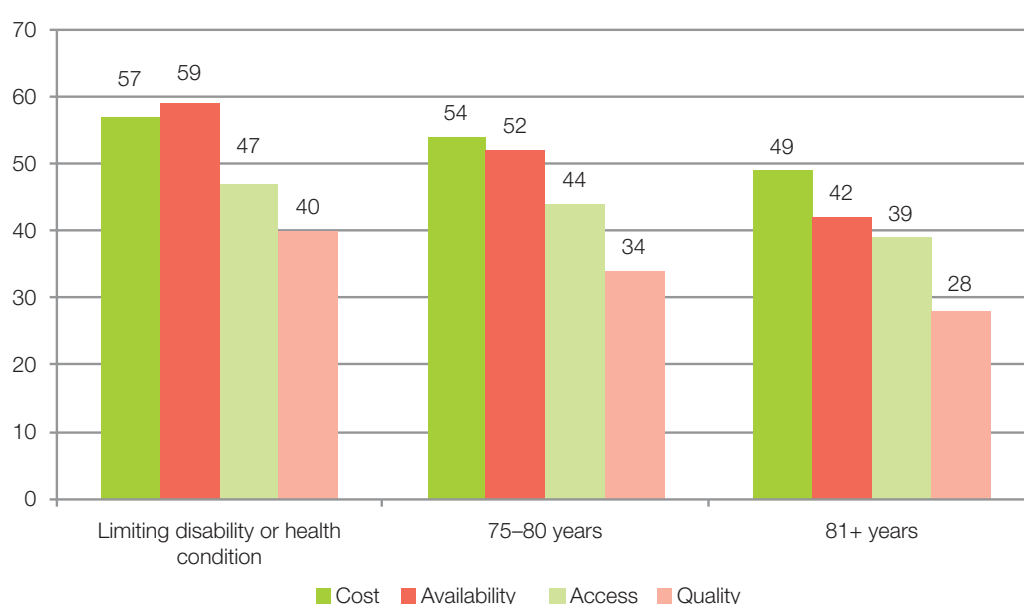
- demographics (that is, the increasing share of people aged 80+ in the population with a decreasing proportion of the working-age population who provide the potential pool of informal carers);
- increasing participation of women in the labour market;
- increasing provision of long-term care within the home.

Childcare

The provision of affordable and quality childcare services is another key public policy challenge in many Member States. Affordable and quality childcare is increasingly recognised as fostering gender equality by helping to reconcile work–life balance. These services are central to active labour market policies and the removal of barriers and disincentives to employment affecting women and single parents (European Commission, 2009c), disabled people (Zaidi, 2012b) and the unemployed.

The importance of childcare services was recognised at the EU level in the Barcelona targets and the goal of providing childcare

Figure 13: Percentage of users of long-term care services reporting difficulties in using those services, EU27



Note: Q56 To what extent did each of the following factors make it difficult for you or not, or someone close to you, to use long term care services? a. Cost, b. Availability, c. Access, d. Quality of care.

to at least 90% of children between three years old and mandatory school age and at least 33% of children under three years of age by 2010 (Eurofound, 2006; European Commission, 2009c). The provision of affordable, quality childcare is central to the EU Strategy for Equality between Women and Men 2010–2015 (European Commission, 2010b). Early education promotes cognitive development of children especially in the pre-school stages (aged three and over), with benefits for disadvantaged children particularly marked (Gambaro et al, in press).

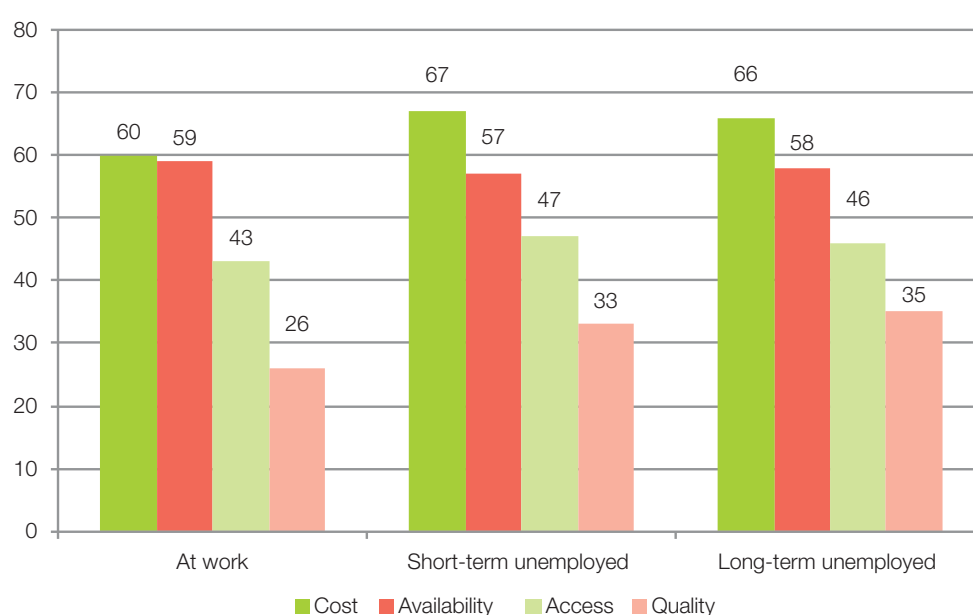
As with long-term care, there is considerable variation across EU Member States in how childcare services are provided. Key variables include (Gambaro et al, in press):

- the level of public expenditure;
- the share of public, private and voluntary sector provision;
- the use of subsidies;
- the extent of compulsion;
- the extent of universality, rights and entitlements;
- the use of home-based arrangements (for example, child-minding);
- part-time versus full-time childcare arrangements;
- the nature and scope of regulation and monitoring (for example, pupil–teacher ratios, qualifications and training, the use of prescriptive curriculum guidelines, regulation and evaluation by formal bodies).

Evidence drawn from EU-SILC data suggests that there is considerable variation in participation rates in formal childcare, the extent to which part-time and full-time childcare models are adopted in different Member States, and the extent to which formal childcare arrangements are supplemented by informal care arrangements with family and friends playing an important role (European Commission, 2009c, pp. 34–38). Some Member States (for example, the Netherlands) are currently engaged in programmes of market reforms, with direct state provision being abolished in favour of state subsidies and diverse providers (Gambaro et al, in press).

The third EQLS asked users of childcare about difficulties with costs, availability, access and quality. Details are provided in the overview report (Eurofound, 2012b). Like long-term care, high proportions of users reported difficulties in accessing and using childcare. The main problem identified by users was cost; difficulties were most pronounced in the EU12 countries. At the individual country level, 78% of users in Greece, Malta and the UK and 74% of those in Slovenia identified difficulties with cost. Sweden was an outlying good performer, with only 11% of users identifying cost as a difficulty. However, even in Sweden, 18% of users identified difficulties with the quality of childcare, a figure that rose to 25% in the UK, 38% in Poland and Slovakia, and 63% in Greece.

Figure 14: Percentage of users of childcare reporting difficulties with childcare quality, EU27



Note: Q55 To what extent did each of the following factors make it difficult or not for you, or someone close to you, to use childcare services? a. Cost, b. Availability, c. Access, d. Quality.

Users who have a limiting disability or health condition and the unemployed were more likely than other users to report difficulties with the cost of childcare services. Lack of childcare is an important barrier to employment, and disparities here have important implications for EU public policy initiatives including:

- the implementation of the gender equality and the disability strategies;
- the integration of women, including single mothers, and disabled people into the labour markets;
- the delivery of targets to combat poverty and social exclusion by 2020.

Users of childcare who were unemployed were more likely than those in work to identify difficulties with quality, with the disparities most marked among the long-term unemployed (Figure 14). Public action is required to address quality gaps of this type and to ensure that all childcare services promote the cognitive development of children and safeguard them from neglect and abuse.

The findings also raise the question of whether there is a tendency for more disadvantaged children to use lower-quality childcare. Gambaro et al (in press) found no evidence of differentials in childcare quality between disadvantaged and more advantaged children in a number of European countries including Germany, the Netherlands and Norway. In England, where disadvantaged children are more likely to be using public rather than private childcare, a reverse pattern emerged for children over three years of age. Children from disadvantaged families were found to be clustered in publicly provided childcare, which outperformed the private sector on one indicator of quality, namely, graduate-led provision. Magnuson and Waldfogel (in press) report evidence from the US that children from low-income homes attend early childhood education and care that is, on average, of lower quality than that attended by other children.

The findings based on the Eurofound data suggest that further research is required into the quality of childcare used by more disadvantaged children, and users' perceptions of quality and what constitutes good-quality childcare.

CHAPTER 4

Productive and valued activities

Productive and valued activities

Productive and valued activities include employment but also other non-market activities such as the provision of unpaid care to elderly and disabled people, childcare and volunteering. This chapter seeks to develop an evidence base on informal caring activities (Indicator 6).

The EQLS is not a specialist employment survey and therefore trends in unemployment are not reported in detail here. However, some preliminary comments are presented relating to unemployment and employment as broader context for the productive and valued activities domain.

Context

As noted in the Introduction, there is growing concern across Europe about the impact on employment of the crisis that began late 2007 and erupted into a full-blown economic crisis in 2008. The crisis is also impacting on the working conditions of those who remain employed.

A recent study for the International Labour Organization (ILO) provides evidence on the impact of the crisis on inequalities in European countries (Vaughan-Whitehead et al, 2012) covering employment, wages and incomes, working conditions and social dialogue. The study found that the crisis has deepened inequalities and that certain categories of workers have been hit more than others. The first source of inequality resulting from the crisis was the asymmetric impact of employment adjustments on different sections of the workforce, with workers on temporary or agency contracts being disproportionately adversely affected. For example, 90% of employment losses in Spain affected temporary workers. Another finding was that young people have been hard hit by rising rates of youth unemployment in almost all European countries, but particularly in the three Baltic countries, Ireland and Spain. The construction and manufacturing sectors were reported to have been adversely affected. These sectors employ relatively many low skilled men. Declines in real wage progression were found to be notable in the public sector. Other key findings include evidence of increases in the gender pay gap, of the reduction or removal of arrangements to reconcile work and family life, and increasing stress at work for female workers.

Official unemployment statistics do not reflect 'discouragement effects' whereby discouraged workers do not identify themselves as unemployed and actively seeking work. Instead, they are integrated into the economically inactive population, for example, by enrolling in education or training, through retirement or by becoming homemakers. It is therefore important to track the percentage of the working age population in employment alongside the unemployment rate.

Based on an analysis of EQLS data, the percentage of the working age population (women under 60 years and men under 65 years) in paid employment decreased significantly by 2 percentage points between 2007 and 2011. The percentage point change was less for women than for men, and was greater for individuals aged 18–24 than for older age groups – confirming the picture of the severe adverse consequences of the economic downturn for youth in many Member States.

Disparities by disability

The position of working age people with disabilities – already disadvantaged in 2007 – appears to have deteriorated in the period to 2011. The proportion of working age individuals with a limiting disability or health condition in employment fell at a faster rate than for the general population (by 4 percentage points). This figure confirms the fears expressed in the European Disability Strategy that the economic downturn might impact disproportionately on people with disabilities (European Commission, 2010c).

It has been established elsewhere that disabled people are less often in employment than non-disabled people (Zaidi, 2011). Economic inactivity among young people aged 16–24 years is particularly high, and the number of younger people with health problems accessing disability benefit systems across the EU has increased considerably (Eurofound, 2010a). As recognised in the European Disability Strategy and the evaluation of the European Year for Combating Poverty and Social Exclusion 2010 (Cancedda and McDonald, 2011), disability mainstreaming and active labour market policies that recognise the different needs and situations of people with disabilities are required to address these disparities and to prevent social inequalities widening even further as a result of the crisis.

Indicator 6: Informal care

The OECD defines informal carers as people providing assistance with basic activities of daily living for at least one hour a week (OECD, 2012). It is important to distinguish between the provision of a limited number of hours of informal care and intensive informal caring activities (more than 20 hours a week). According to OECD analysis, intensive caring activities are associated with reduced labour force attachment and higher prevalence of poverty and mental health problems (OECD, 2011, p. 170).

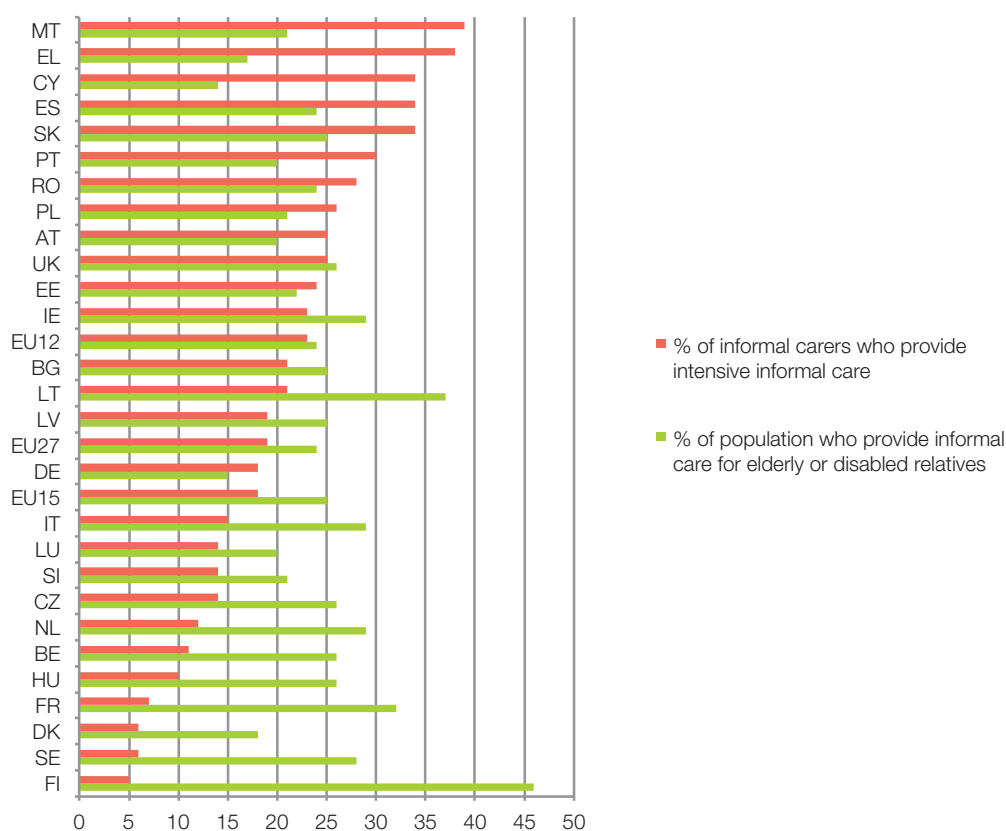
Informal caring is still mainly undertaken by women. As recognised in the EU gender equality strategy (European Commission, 2010b), there is a need for public policy frameworks that recognise, value and support the provision of unpaid care by women as well as the decision of women to work. A dual strategy that aims to support informal carers while expanding their employment options reflects the idea that autonomy is

in itself a key public policy goal. Policy should aim to expand the substantive choices that women have in combining and reconciling their caring and working roles.

Older people also make a major social contribution as providers of unpaid care. A key goal of the European Year for Active Ageing and Solidarity between Generations 2012 was to promote recognition of the social contribution of older people – including their role as informal carers.

Figure 15 shows a low correlation between the provision of a limited number of hours of informal care for the elderly and the provision of intensive informal caring activities within Member States. In Denmark, Finland and Sweden, for example, a relatively high proportion of the population reported providing informal care for the elderly, but the prevalence of intensive caring activities among informal carers was relatively low. The long-term care systems in this cluster of countries appear to

Figure 15: Percentage of population in EU Member States providing informal care for elderly and disabled relatives



Notes: The minimum weighted base for intensive caring activities is 63.

Q36 In general, how often are you involved in any of the following activities outside of work? c. Caring for elderly or disabled relatives with options 1. Every day, 2. Several days a week, 3. Once or twice a week, 4. Less often, 5. Never.

Q37 [asked if answer to Q36c is 1, 2 or 3] On average, how many hours per week are you involved in any of the following activities outside of paid work? c. Caring for elderly or disabled relatives.

be successfully protecting individuals from exposure to the burden of intensive caring activities. In southern Mediterranean countries such as Cyprus, Greece and Malta, the proportion of the population undertaking informal caring activities for the elderly was lower, but the prevalence of intensive caring activities among informal carers was higher.

Many of the informal carers who provided intensive caring were themselves older people or had a limiting disability or health condition. At the EU27 level, of those informal carers aged between 75 and 80 providing care for elderly or disabled relatives, 36% reported that they undertook informal caring activities for 20 hours a week or more. Among informal carers aged 81 or over, the proportion increases even further, to 42%. Among informal carers who themselves had a limiting disability or health condition, 28% reported undertaking caring activities for 20 hours a week or more (Figure 16).

Policy options for supporting unpaid carers include:

- encouraging flexible working hours;
- payments to non-professional carers;
- opportunities for respite care.

In addition to having disabilities or unmet health needs, older carers lack sources of social support. These could be addressed by integrating assessment of the needs of informal carers into social care policies and strategies.

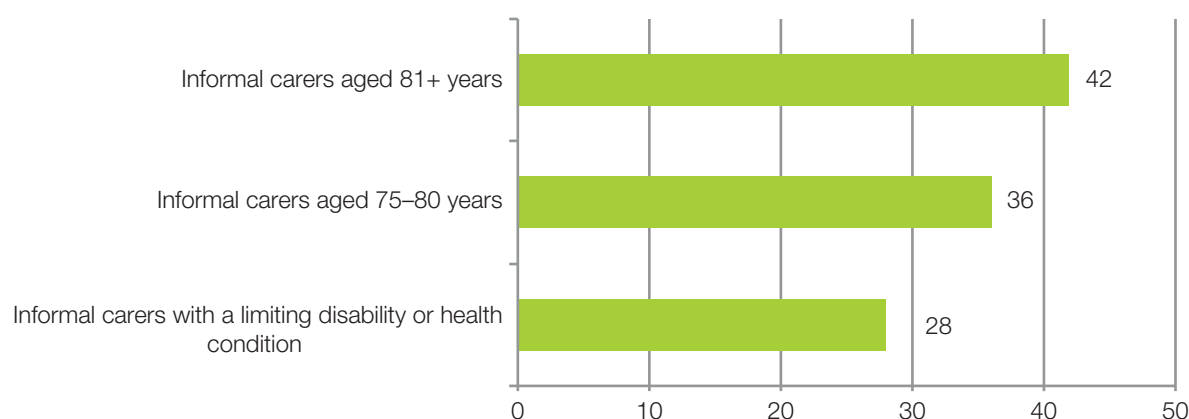
Public policy frameworks that recognise, value and support the role of informal carers are emerging in some Member States. In a number of countries (mainly northern and continental European countries), there are arrangements to at least partially fund informal care. These involve either direct payments to informal carers or the provision of care budgets to

care recipients. For example, Denmark allows relatives and neighbours providing regular home care to become regular municipal employees, with complete benefits including regular pension benefits. In Finland, informal caregivers receive a fixed fee from municipalities as well as pension payments. In Austria, Germany, Luxembourg and the Netherlands, cash payments are made to care recipients that can be used to pay informal care providers (Saltman et al, 2006; OECD, 2011).

Research by Eurofound on measures taken by companies in 11 EU countries to support workers with care responsibilities shows that levels of awareness among managers, supervisors and staff about working carers for the elderly and people with disabilities can be lower than awareness of working parents (Eurofound, 2010b). However, examples of good practice such as the provision of additional paid leave days were identified.

While the provision of care for older people at home has been an important priority in a number of Member States, the availability of support for informal carers has been limited, with sharp variations between northern and southern European countries (Eurofound, 1993a, b, c, 1995). The promotion of partnerships between informal and professional carers has featured prominently in recommendations (for example, Alaszewski et al, 2003; Banks, 2004; Nies, 2004). Some have argued that the wider availability of support for informal carers should be among the foremost policy aims for Europe (Kröger, 2003).

Figure 16: Percentage of selected subgroups providing intensive caring activities for the elderly, EU27



Notes: Intensive caring is defined as providing caring for 20 or more hours a week.

Q36 and Q37 (see Figure 15 for wording)

CHAPTER 5

Individual, family and social life

Individual, family and social life

The capability to enjoy individual, family and social life covers aspects of individual life such as individual autonomy, dignity, social isolation, family and social relationships, social networks, support in times of need, social capital, social integration and inclusion. Findings for this domain are reported here against four indicators:

- Indicator 7: autonomy;
- Indicator 8: dignity and respect;
- Indicator 9: social support;
- Indicator 10: perceived social exclusion.

Indicator 7: Autonomy

The importance of autonomy in the capability approach is discussed in Chapter 1. Studies in this area include Burchardt et al (2012) and Burchardt and Holder (2012). The latter provides empirical evidence on inequalities in the autonomy enjoyed by different population subgroups in the UK. Scores against an overall autonomy scale focusing on whether people are able to do the things in life that are important to them were found to be high. Having a limiting disability or health condition, being from a lower occupational group and having lower educational qualifications were found to be negatively associated with autonomy.

Based on the data from the third EQLS, scores for overall autonomy were also found to be high at the European level. The proportion of individuals who report feeling free to decide how to live their life was 87% in the EU27 countries on average. The proportion in most countries was above 80%, with the highest percentages being 96% in the Netherlands, 95% in Malta, 94% in Austria and Denmark, 93% in the Czech Republic and 90% in Finland. However, in Hungary, the percentage was lower at 75%. Greece was an outlier relative to other countries, with only 54% of individuals reporting feeling free to make decisions in their lives.

Disadvantage in the individual, family and social life domain was found to vary considerably among population subgroups

(Table 3). At the EU27 level, women were slightly more likely to report feeling free to make decisions in life than men (87% versus 86%). However, at the EU12 level, the variation reversed, with women less likely than men to report feeling free to make decisions in life (85% versus 87%).

Disparities by economic status

Unemployment is often associated with feelings of disempowerment, loss of control and fatalism. Unsurprisingly, unemployed people in Europe are particularly disadvantaged in relation to perceived autonomy.

People whose employment status was 'short-term unemployed' were less likely than the employed or self-employed to report feeling free to decide how to live their life; the disparities are even more pronounced for the long-term unemployed (Table 3 and Figure 17).

Perceived lack of autonomy and feelings of disempowerment, loss of control and fatalism can constitute important barriers to labour market re-entry. These feelings need to be addressed in active labour market policies, particularly by promoting soft skills through training programmes for the long-term unemployed.

Indicator 8: Dignity and respect

Treatment with dignity and respect is underpinned by the European Convention on Human Rights and the European Union's Charter of Fundamental Rights, and is another critical aspect of people's life that is associated with systematic social inequalities. The importance of developing quantitative indicators of treatment with dignity and respect was highlighted in recent human rights monitoring exercises (for example, Candler et al, 2011). The European Council designated 2010 the European Year for Combating Poverty and Social Exclusion, the goals of which included recognition of the fundamental right to dignity of people living in poverty and social exclusion.

Table 3: Comparison of disadvantage across subgroups in the individual, family and social life domain

		Autonomy (%)	Not treated with dignity/ respect (%)	No social support (%)	Perceived social exclusion (%)
Gender	Male	86	18	30	12
	Female	87*	16	29	12*
Health	No limiting disability or health condition	88	15	26	10
	Limiting disability or health condition	81*	23*	44*	19*
Age group	18–24 years	91	20	12	10
	25–34 years	86*	22	18*	11*
	35–49 years	84*	20	21*	13*
	50–64 years	85*	17	34*	12*
	65–74 years	90*	10*	55*	11*
	75–80 years	91	9*	64*	12*
	81+ years	89*	7*	65*	13*
Economic status	Employee, employer or self-employed	88	16	20	9
	Unemployed less than 12 months	78*	29*	25*	17*
	Unemployed 12 months or more	72*	38*	33*	30*
	Unable to work due to long-term illness	72*	43*	41*	34*
	Retired	89*	11*	56*	12*
	Full-time homemaker	86*	21*	28*	13*
Citizenship	EU citizenship	87	17	30	12
	Non-EU citizenship	88	27*	24	18*

Notes: For each population subgroup, the reference group is highlighted in bold. * = statistical significance of difference from reference group reported at the 5% significance level and has been tested using a one-variable logistic regression test. Rounding of values makes the significant male–female difference in perceived social exclusion not apparent.

Social support Q35 From whom would you get support in each of the following situations? a. If you needed help around the house when ill, b. If you needed advice about a serious personal or family matter, c. If you needed help when looking for a job, d. If you were feeling a bit depressed and wanting someone to talk to, e. If you needed to urgently raise [amount, rounded near 1/12th of annual national at-risk-of-poverty threshold] to face an emergency. Options: 1. A member of your family/relative 2. A friend, neighbour, or someone else who does not belong to your family or relatives, 3. A service provider, institution or organisation 4. Nobody.

Autonomy/perceived social exclusion/treatment with dignity and respect Q29 Please tell me whether you strongly agree, agree, neither agree or disagree, disagree or strongly disagree with each statement. c. I feel I am free to decide how to live my life, e. I feel left out of society, h. Some people look down on me because of my job situation or income. Note that the neutral option 'neither agree nor disagree' has been coded to 'missing' for the purposes of this table.

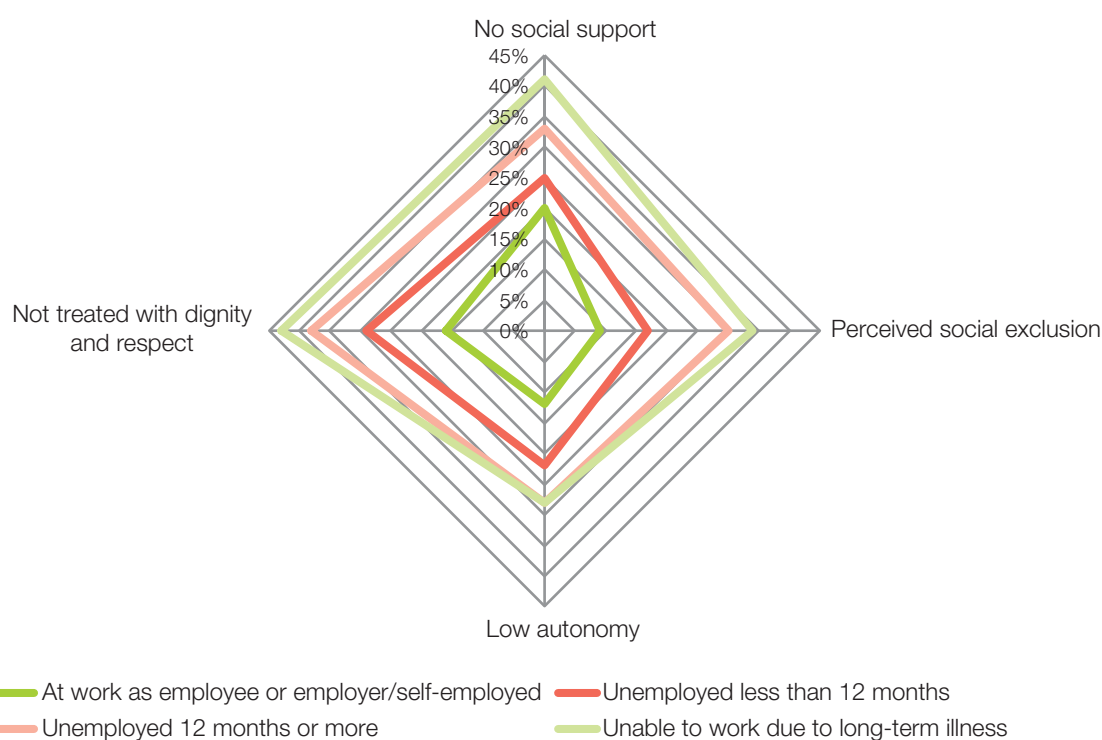
Disaggregated findings from the third EQLS on self-reported lack of treatment with dignity and respect ('being looked down on') are presented in Table 3. Unemployed people are disadvantaged against this indicator, with the disparities again particularly pronounced among the long-term unemployed. Those who have a limiting disability or health condition are also at particular risk.

Disparities by citizenship are also important here. At the EU27 level, non-EU citizens were more likely than EU citizens to report feeling looked down on (27% versus 17%). Similar disparities are observed at the EU15 level, with non-EU citizens more likely than EU citizens to report feeling that they were looked down on by others (26% versus 15%).

Indicator 9: Social support

Having a source of social support, particularly in times of need, is of central importance to the capability for individual life. Social support provided by friends, families, religious organisations, non-governmental organisations (NGOs), public services and others is critical for the resilience of individuals and their ability to cope. Having a source of social support is also vital for other capabilities, such as the capability to enjoy good health. For example, lack of social support was highlighted in Chapter 2 as an important risk factor for bad self-rated general health. This finding is consistent with evidence in the broader research literature. For example, Kumar et al (2012) pointed out that higher levels of social support are linked to lower levels of strain, particularly for women, and that social support, particularly familial ties, was beneficial for cardiovascular and other aspects of health.

Figure 17: Disparities in the individual, family and social life domain, according to employment status, EU27



Notes: Data points that are further out on the radar diagram indicate worse outcomes against each indicator. The severity of disadvantage against different indicators is not necessarily comparable.

Q35 and Q29 (see Table 3 for wording)

The EQLS asks respondents to whom they would turn to:

- get support if they need help around the house when ill;
- seek advice about a serious personal or family matter;
- ask for help when looking for a job;
- when feeling depressed and wanting someone to talk to;
- raise a sum of money in an emergency.

The analysis here looks at the proportion of the population who indicated they had no source of support ('nobody') in at least one of these situations.

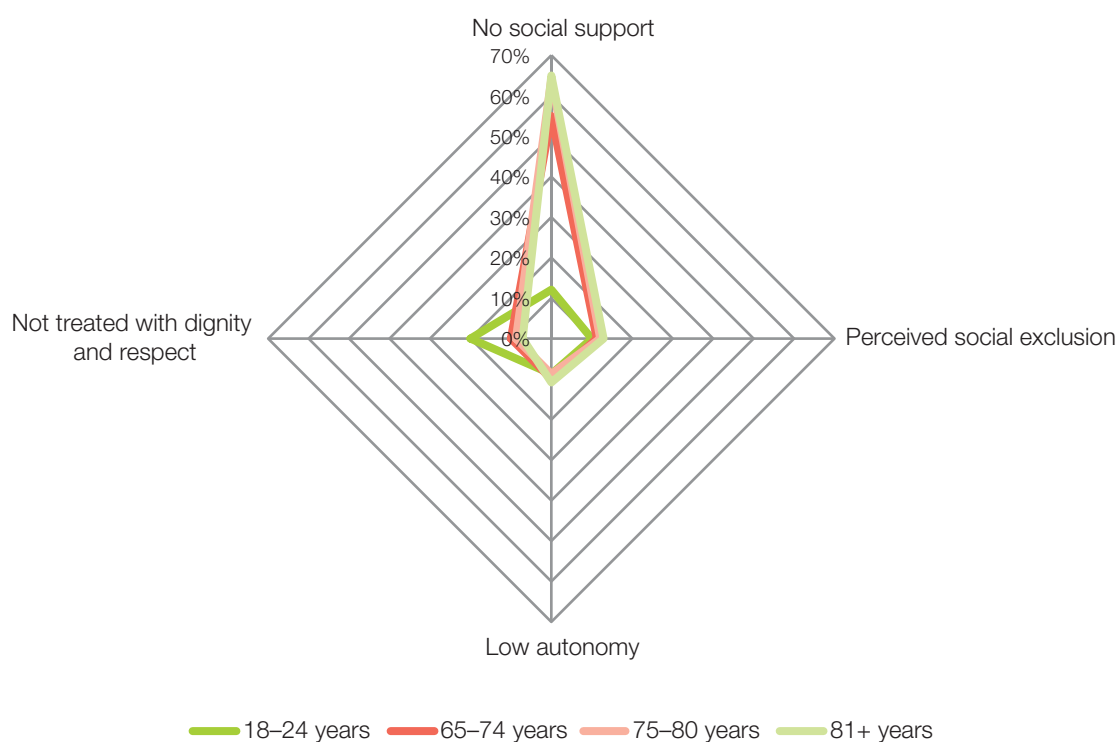
In an interesting reversal of the findings for other domains, the overall percentages of those reporting in the third EQLS that they have no source of social support is higher in the EU15 countries than in the EU12 countries. A similar finding is observed in relation to disability status. While the proportion of individuals with a limiting disability or health condition who had no source of support was high across Europe, this

proportion was somewhat lower on average in EU12 countries (35%) than in EU15 countries (47%). However, the relative gaps between those with a limiting disability or health condition and those without were similar for both country groups (18 and 19 percentage point gaps respectively).

Lack of social support among older people

Older people are at particular risk in relation to social support and social exclusion (Table 3 and Figure 18). Individuals in the 75–80 age group were more likely than those in the 18–24 age group to report having no social support at the EU27 level (64% versus 12%). The disparities were even more pronounced for the 'oldest of the old', with those aged 81 or over even more likely to report having no social support (65%). Again, the overall disadvantage levels for older people were notably lower in EU12 countries (44% for 75–80-year-olds and 50% for those aged 81 or over).

Figure 18: Disparities in the individual, family and social life domain according to age group, EU27



Notes: Data points that are further out on the radar diagram indicate worse outcomes against each indicator. The severity of disadvantage against different indicators is not necessarily comparable.

Q35 and Q29 (see Table 3 for wording)

Indicator 10: Social exclusion

Eurostat uses an indicator covering three dimensions (poverty risk, material deprivation and low work intensity – the so-called AROPE measure) to monitor progress against the Europe 2020 headline target to lift at least 20 million people out of the risk of poverty and social exclusion by 2020. This report provides an evidence base on a direct measure of perceived social exclusion, based on a question in the EQLS about whether people feel excluded from society.

In this context, gender and disability mainstreaming were key goals of the agenda for the 2010 European Year for Combating Poverty and Social Exclusion. However, the European Commission's evaluation of the year's achievements suggests that progress was very limited (Cancedda and McDonald, 2011).

Findings from the third EQLS suggest that of those who expressed an opinion, women were, statistically speaking, significantly less likely than men to report feeling left out of society in EU27 countries, although the difference here was very small – 11.62% versus 12.06%. In the EU12 women were more likely than men to report feeling left out of society (15% versus 13%). In contrast, in the EU15 men were more likely to report feeling left out of society (12% versus 11%). Disparities

by economic status were marked, with the unemployed and economically inactive subgroups (people unable to work due to illness, retired people and full-time homemakers) all at risk. Those with a limiting disability or health condition were also more likely than those without to perceive themselves as being socially excluded.

Is older age a risk factor?

As noted in Chapter 3, older people faced a lower risk of poverty or social exclusion in 2011 than the overall population both at EU27 level and in 16 out of the 26 countries with available data. However, the risk of poverty or social exclusion faced by people aged 65 or over in 2011 varied considerably across Member States.

The findings from the third EQLS suggest that older age is a risk factor for perceived social exclusion in EU12 countries. Within this country cluster, perceived social exclusion increased notably with age, rising to 19% among those aged 65–74 years, 20% among 75–80-year-olds and 21% among those aged 81 or over. Similar findings are reported by Eurofound (2012b), which identified an upward trend in social exclusion by age using an index-based approach.

Box 5: Distribution of social exclusion

At the EU27 level, the 20% of the population with the lowest level of perceived social exclusion (quintile 1) had an average score of 2.3, while the 20% with the highest perceived social exclusion (quintile 5) had an average score of 5. However, variation in the distribution of social exclusion at the individual country level was apparent. For example, in the Netherlands, the distribution ranged from an average score of 3.3 in quintile 1 to an average score of 5 in quintile 5. In Slovakia, the distribution ranged from 2.5 to 5, while in Greece, the range was from 2 to 5.

Impact of the crisis

The proportion of individuals in EU27 countries who reported feeling 'left out of society' increased from 10% to 12% on average (an increase of 2 percentage points) between 2007 and 2011. At the individual country level, there were increases in the proportion perceiving themselves to be socially excluded in a number of Member States, including an increase from 8% to 23% (up 14 percentage points) in Cyprus, from 8% to 17% (up 9 percentage points) in the Czech Republic, from 7%

to 10% (up 3 percentage points) in Germany and from 12% to 18% (up 6 percentage points) in Greece. Other significant increases occurred in Denmark, Estonia, France, Luxembourg and Spain.

At the EU27 level, increases in the proportion perceiving themselves to be socially excluded were notable among both men and women. Increases were also recorded among those in work and those aged 35–49 and 50–64.

Box 6: Risk factors and protective factors for social exclusion

To examine the risk factors and the protective factors associated with disadvantage in the individual, family and social life domain in more depth, a multilevel regression analysis was undertaken using the EQLS 2011. As noted earlier, this type of analysis is not intended to provide a full explanatory model but to provide a basis for a broader and more in-depth discussion of the drivers of perceived social exclusion and as a guide to policy recommendations.

Other studies in this area include Pirani and Schifini (2010), who found that perceptions of social exclusion are heavily influenced by the economic dimension (such as employment status and not being able to make ends meet) but that relational aspects (family, community and social relations) can mediate the impact of economic status. Age was also found to be an important driver of perceptions of social exclusion, resulting in the policy conclusion that differential forms of social support are required for different population subgroups. Further analysis is provided in Pirani (2012, 2013).

The particular risks of social exclusion facing older people in Europe are also discussed by Jehoel-Gijsbers (2008) who operationalised the concept of social exclusion in a multilevel regression exercise in terms of measures of material deprivation and social rights (focusing on housing and access to medical and dental care). A key finding was that older age groups are not at greater risk than younger age groups, with pensions systems playing a role. Among older people over the age of 65, the authors also found that country-level income inequality was a strong predictor.

Eurostat (2013b) found that people aged 65 and over faced a lower risk of poverty or social exclusion in 2011 than average. The situation of the elderly was found to depend on factors such as pensions systems, and the age and gender composition of the older population. Older women and the very old faced higher risks in some countries.

In the first stage of the modelling exercise, controls were introduced for gender, age, disability, economic status and citizenship. The following factors were found to have a significant association:

- having a limiting disability or health condition;
- being unemployed;
- being a non-EU citizen.

In the second stage of the modelling exercise, controls were introduced for a broader range of individual socioeconomic characteristics. The following variables were found to be associated with a higher probability of perceived social exclusion (Figure 19), after controlling for other factors:

- poverty (being income poor or deprived in all items of the material deprivation measure);
- education – having lower rather than higher educational qualifications;
- being in a non-professional or non-managerial occupational group;
- being a regular unpaid carer for an elderly person;
- marital or partnership breakdown;
- being widowed and not living with a partner;
- living in poor-quality housing;
- perceiving tension between population subgroups (poor and rich people; management and workers; men and women; old and young people; different racial and ethnic groups; different religious groups; people with different sexual orientation);
- not having children;
- not participating in collective social activities;
- having bad self-rated general health;
- having no source of social support;
- living in an urban area.

Introducing controls such as being a carer or being widowed and provision of informal care has an impact on the analysis of the association between ageing and perceived social exclusion. Even after controlling for these factors, being aged 81 or over was found to increase the risk of social exclusion.

In the third stage of the research exercise, the association of macro-variables including GDP per capita and income distribution (Gini coefficient) with perceived social exclusion were examined. Neither variable was found to be significant after controlling for other factors.

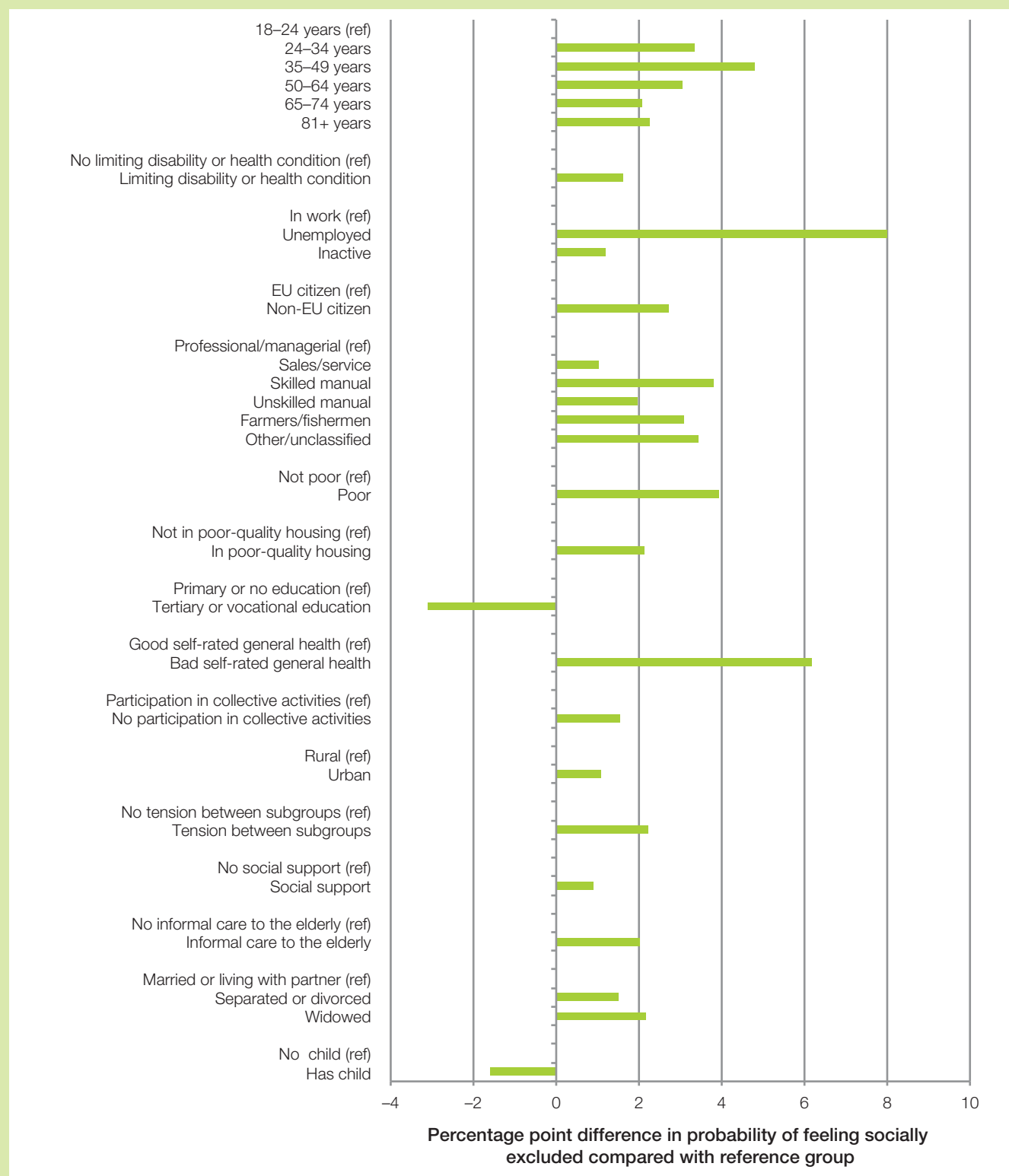
In a further exploratory analysis, the impact of different types of healthcare system and welfare regime was considered. The caveats highlighted in Box 1 should be noted here. Living in a country with healthcare system 2 (lower public, medium private) and 3 (higher out-of-pocket payments) was observed to be associated with perceived social exclusion relative to healthcare system 1 (higher public financing) after controlling for other factors. Living in a country with welfare regime type 2 (corporatist), type 3 (liberal), type 4 (southern Mediterranean), type 5 (post-socialist corporatist) and type 7 (residual) was observed to be associated with perceived social exclusion compared with living in a country with type 1 (social democratic) (controlling for other factors, under an 'in work' assumption).

A significant interaction between employment status and welfare regime was also observed, with the impact of unemployment depending on welfare regime. The impact of unemployment on perceived social exclusion was found to be weaker under welfare regime type 2–7 assumptions than under the welfare regime type 1 (social democratic) assumption.

Overall, the findings highlight the need for Member States to address the needs and situations of those who have a limiting disability or health condition, the unemployed and non EU-citizens in their general social exclusion strategies. Those aged 81 or over are at particular risk, together with older people in other age groups who lack social support, who are regular carers or are widowed. Whereas Jehoel-Gijsbers and Vrooman (2008) questioned the emphasis of the European Commission (2006a, b) on policy measures that specifically addressed social exclusion among the elderly, the findings here suggest such measures are required.

The findings suggest that disability mainstreaming is a pressing concern in many Member States. The analysis also points to the relevance of additional elements of social exclusion not necessarily captured in the composite indicator used to monitor progress towards the Europe 2020 targets. Whereas this indicator captures and reflects income poverty risks, material deprivation and lack of work, a broader monitoring instrument and multidimensional strategies may be required to address drivers such as tension between subgroups, bad self-rated general health and poor-quality housing.

Figure 19: Variation in the risk of perceived social exclusion, by socioeconomic characteristics, EU27



Notes: Based on multilevel logistic regression analysis; predicted probabilities based on fixed portion of model only. 'ref' indicates the reference group.

CHAPTER 6

Conclusions, key findings and policy pointers

Conclusions, key findings and policy pointers

There is evidence of pervasive social inequalities in the distribution of four critical capabilities in Europe in 2011. Social inequalities in health, standard of living, productive and valued activities, and individual, family and social life have been identified by gender, age, disability, employment status and non-EU citizenship at the EU27, EU15 and EU12 levels. In some instances, there is evidence of disadvantages becoming more prevalent and social inequalities widening between 2007 and 2011.

Summary of findings by domain

Health

- Women, older people and unemployed people were found to be disadvantaged across a range of health indicators in 2011. People who reported a limiting long-standing physical or mental health problem, illness or disability (referred to in this report as a 'limiting disability or health condition') were found to be more likely to experience difficulties in accessing healthcare, including difficulties with cost.
- Having a limiting disability or health condition, being older and being unemployed were found to have a negative impact on self-reported health, even after controlling for other factors. Material deprivation, low income, low educational attainment, poor-quality housing and perceived difficulties in accessing healthcare were also found to be important.
- The proportion of the EU27 population reporting bad self-rated general health increased between 2007 and 2011, particularly among low-income groups. The proportion of young people whose mental health is at risk increased, suggesting that the scarring effects of the crisis may be affecting their health and well-being.

Standard of living

- People who have a limiting disability or health condition, older people (particularly in EU12 countries), unemployed people and non-EU citizens are more likely to experience material deprivation.
- Income, occupational group and education level were found to have an effect on material deprivation after controlling for other factors. Widowhood, lack of social support, GDP and social arrangements for welfare were also found to be important.
- The proportion of the EU population who experienced material deprivation increased between 2007 and 2011. Above-average increases were observed among those with a limiting disability or health condition, the long-term unemployed and those aged 50–64.
- High proportions of users of long-term care, including users with a limiting disability or health condition and older users, were found to experience difficulties with the services they received. Difficulties with childcare cost and quality are particularly pronounced among the unemployed.

Productive and valued activities

- Informal care activities are still mainly undertaken by women.
- Older people and people with a limiting disability or health condition were found to be making a major social contribution as providers of informal care in Europe.
- Informal carers of older people with a limiting disability or health condition and those aged 65 and over are often

engaged in intensive informal care activities (that is, they often provided informal care for 20 or more hours a week).

Individual, family and social life

- Having a limiting disability or health condition and being unemployed were found to be associated with disadvantage against each indicator in the individual, family and social life domain. Older age was found to be a risk factor for lack of social support, with the disparities most pronounced for those aged 81 or over. Older age was found to be a risk factor for perceived social exclusion in the EU12 countries. Non-EU citizens were more likely to report feeling they are treated with a lack of dignity and respect, and to perceive themselves as being socially excluded.
- Poverty (being income poor or being unable to afford all the items of the material deprivation indicator), education and occupational group were found to have an effect on perceived social exclusion. Being aged 81 or over, widowhood and lack of social support were also found to be important.

Summary of cross-domain findings by disaggregation characteristics

Gender

- Social inequalities by gender were identified in a number of domains. In the health domain, women are disadvantaged against a range of indicators. There is an association between being female and material deprivation after controlling for other factors.
- Responsibility for unpaid caring activities still falls predominantly to women, who are more likely than men to report undertaking both unpaid care for older people and intensive unpaid caring activities.

Disability status

- Having a limiting disability or health condition stands out as being associated with systematic social inequalities across a wide range of domains.
- Individuals with a limiting disability or health condition were found to be consistently disadvantaged across all the domains considered in this report and against virtually all the 10 indicators in the dashboard.

- Against some indicators (for example, material deprivation) the position of disabled people, already disadvantaged in 2007, has deteriorated following the economic crisis that began in late 2007.

- The association between having a limiting disability or health condition, bad self-rated general health, material deprivation and perceived social exclusion was confirmed after controlling for other factors.

Age

- Increases in the risk of poor mental health over the period 2007–2011 were observed for 18–24-year-olds (up 3 percentage points) and 50–64-year-olds (up 2 percentage points). The findings suggest that these severe adverse effects of the crisis on young adults are not limited to unemployment but also extend into other critical areas of life.
- It is often assumed that the position of older people in Europe is protected effectively by pension systems and other social benefits. However, the report's findings suggest that older people are at risk in a number of quality of life domains and that the disparities are often most pronounced among the 'oldest of the old' (defined here as individuals aged 81 or over). This was apparent, for example, in the context of bad self-rated general health, the risk of poor mental health, feeling downhearted, loneliness, having no source of social support (particularly in the EU12 context) and perceived social exclusion (in the EU12 context).
- Being aged 81 or over increases the risk of social exclusion after controlling for other factors.

Economic status

- With unemployment high in Member States hit hard by the crisis, the multidimensional disadvantages experienced by unemployed people are a pressing public policy concern.
- Unemployed people are more likely to be at risk of poor mental health and to experience material deprivation. Gaps between the working population and the long-term unemployed (that is, those unemployed for more than 12 months) are most pronounced.
- After controlling for other factors, an association was identified between being unemployed and bad self-rated general health, material deprivation and perceived social exclusion.

- The prevalence of material deprivation among the long-term unemployed increased more than in the general population between 2007 and 2011.

Citizenship

- Non-EU citizens stood out as experiencing particular social disadvantages in relation to perceived social exclusion, and lack of dignity and respect in the treatment they receive (that is, feeling that they are looked down on by others).
- After controlling for other factors, there is an association between being a non-EU citizen and material deprivation and perceived social exclusion.

Summary of findings on change 2007–2011

- Concerns have been expressed elsewhere that the impact of the economic crisis may adversely affect social inequalities according to characteristics such as gender and disability. This report's findings suggest that overall population outcomes have deteriorated since 2007 against a number of indicators. In some instances, there is evidence that the position of subgroups that were already disadvantaged in 2007 has deteriorated in line with these overall population declines.
- Against a more limited number of indicators, there is some evidence that the position of subgroups that were already disadvantaged in 2007 has deteriorated at a faster rate than on average (or that the rate of improvement has not been in line with the rate of improvement of the general population). In this sense, there is evidence of social inequalities widening for some population subgroups over the period 2007 to 2011.

Policy pointers

Concern with the multidimensional aspects of well-being needs to be coupled with effective public action to address social inequalities. Equality mainstreaming means integrating equality considerations into general policies, including into policy design, implementation, monitoring and evaluation. Public action to address social inequalities should not be restricted to specific measures at the margins, but rather integrated into general policies at the European and Member State levels. To effectively tackle social inequalities, general policies that recognise the different needs and situations of population subgroups are required. For example, active labour market policies are needed that address the different

needs and situations of parents, the long-term unemployed and people with a limiting disability or health condition. With budgets under pressure in many Member States, equality impact assessments can help to ensure that the burden of adjustment does not fall disproportionately on those already most disadvantaged.

Health

- Multidimensional strategies that address the social determinants of poor health, including poor-quality housing, poverty and low educational attainment, should be adopted. With unemployment high in some Member States, policies and strategies that address the poor mental health of unemployed people are required, including multifaceted strategies such as active labour market policies and debt counselling.
- Specific healthcare policies and strategies are required to address the gaps in the health status of those who report having a limiting disability or health condition, older people and unemployed people. These include adjustments to physical environments to ensure accessibility, communication of information into accessible formats such as Braille, and strategies to address the mental health problems and social exclusion faced by older people.
- Public action is required to address the high prevalence of difficulties with healthcare cost among those who have a limiting disability or health condition. Evaluations should determine whether the difficulties experienced are being driven by accessibility (for example, physical environment), lower incomes or higher private health insurance premiums. Additional public policy levers here include minimum standards that prohibit discrimination in relation to goods and services.

Standard of living

- Efforts to mainstream equality concerns into public policy frameworks for reducing income poverty and material deprivation by 2020 should be intensified. In addition to gender and disability mainstreaming, there is a need for public policy frameworks that address the specific needs and situations of the long-term unemployed, including needs for training and childcare.
- Active labour market policies should also recognise that the duration of unemployment is itself a key barrier to work that requires a specific public policy response. Childcare can help to remove barriers to labour market participation by women, including single mothers, and the long-term

unemployed. Public action is required to ensure high-quality childcare as well as its accessibility and availability. This includes ensuring appropriate cognitive development and safeguarding children from neglect and abuse through better regulatory frameworks.

- Low-quality ratings for long-term care throughout Europe – particularly among women and those with a limiting disability or health condition – point towards policy failure. Social insurance provides one possible model and can help to improve the future financial sustainability of long-term care systems. However, special provisions for low-income groups are required. There should also be more emphasis on independent living and autonomy, choice and control in long-term care services.

Productive and valued activities

- As recognised in the EU gender equality strategy for 2010–2015 and the European Year for Active Ageing 2012, public policy frameworks are required that value, recognise and support the contribution of unpaid carers, including women, those with a limiting disability or health condition and older people. Specific policy measures could include opportunities for respite care.
- Older informal carers may themselves have disabilities, unmet health needs and lack sources of social support. The needs of informal carers should be formally evaluated.

- In the context of unpaid women carers, public policy should promote autonomy and choice by expanding the substantive options for women to combine and reconcile care and employment (for example, flexible working hours).

Individual, family and social life

- Public policy frameworks that address lack of social support in times of personal crisis are required. While state-provided services can play a role, policy options here include support for delivery of services by civil society, including by NGOs and volunteer networks.
- The need for gender and disability mainstreaming in policies to address social exclusion are recognised in EU evaluations of progress against the Europe 2020 targets. The report's findings highlight the particular need for social inclusion policies that recognise the needs and situations of older people, especially those aged 81 or over, those who provide regular unpaid care for the elderly and those who are widowed. Policies that recognise the different needs and situations of the unemployed and non-EU citizens are also required.
- Active labour market policies should address perceptions of low autonomy among the unemployed, including feelings of disempowerment, loss of control and fatalism. To address social inequalities in treatment with dignity and respect, there is a need for public policy frameworks that embed a culture of mutual respect and human rights.

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This report examines social inequalities in the distribution of freedoms and opportunities among individuals and population subgroups in Europe. Using data from the European Quality of Life Survey (EQLS), the report builds up an evidence base on social inequalities in four critical areas of life: health, standard of living, productive and valued activities, and individual, family and social life. It examines the role of important determinants of social inequalities including gender, age, disability status, employment status and citizenship status, as well as other drivers. The report finds that, in some instances, there is evidence of disadvantages becoming more prevalent and social inequalities widening between the second wave of the EQLS in 2007 and the third wave in 2011. It recommends that growing policy attention to the multidimensional aspects of well-being be coupled with effective public action to address social inequalities and integrated into general policies at the European and Member State levels.

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